

# Billing procedures



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\*\* This section contains information regarding the EPDST Service: Medical Protocol and Periodicity Schedule and EPSDT/PPHSD Screening Service Codes.

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## INTRODUCTION

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### 1. Introduction

The Fallon Community Health Plan Provider Manual billing section provides you with an overview of our billing requirements. It includes detailed information on our policies and procedures, allowing you to be more efficient in your billing practices.

This manual will be updated as new or revised procedures are established or policies are changed. It is our goal that this manual will make the process of filing claims as easy and trouble-free as possible.

This manual also refers to commonly used codes supplied by the American Medical Association's Manual of Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services Common Procedure Coding System (HCPCS). If you have any comments or suggestions, please contact Provider Relations at 1-866-ASK-FCHP (1-866-275-3247), prompt 4.

Fallon Community Health Plan is a customer driven organization that is dedicated to the prompt and accurate claims payment of our providers' claim submissions in accordance with regulatory and contractual requirements.

## 2. Fallon Community Health Plan's commitment to quality

### A. Claims department quality audits

Fallon Community Health Plan is committed to giving our customers quality service. To ensure claims processing quality, our Claims Department audits claims every month, verifying the accuracy of claims entry and adjudication. The data from these audits is used for additional training and for updating our procedures.

### B. Claim code auditing

In order to keep pace with ever changing medical technology and coding complexities, FCHP has enhanced its claim checking capabilities. FCHP's auditing program exists to evaluate billing and coding accuracy on submitted claims. FCHP's auditing program is guided by the coding criteria and protocols established by various industry sources including the Centers for Medicare and Medicaid Services (CMS), the CPT Manual published by the American Medical Association (AMA) and specialty society guidelines.

FCHP continually evaluates, edits and modifies the auditing program to accommodate FCHP payment methodology.

FCHP implements bi-annual version upgrades to the auditing software. These upgrades typically occur in March and November.

The following list represents an example of the different edits and their definitions.

#### *Age conflicts*

Identifies billed procedure codes that are inconsistent with the age of the member.

#### *Assistant surgeon edits*

Determines if an assistant surgeon is clinically necessary for the billed procedure.

#### *Cosmetic surgery edits*

Identifies procedures that FCHP considers to be cosmetic and suspends the claim for additional review.

#### *Evaluation and management services not paid separately edits*

Identifies the separate reporting of E&M services when a substantial diagnostic or therapeutic procedure is performed. FCHP does not reimburse for E&M services performed on the same day as a procedure unless a significant, separately, identifiable service is documented in the medical record.

#### *Experimental procedures*

Identifies codes that are considered experimental and determined not to be reimbursable by FCHP.

*Gender conflicts*

Identifies billed procedures that are inconsistent with the patient's gender.

*Incidental procedure auditing*

Identifies procedures that FCHP consider to be clinically integral to the primary procedure and not allowable for separate reimbursement.

*Intensity of service auditing*

Compares the ICD-9-CM diagnosis to the intensity of the billed office visit. Recommends the appropriate E&M code and is stated on your Remittance Advice Summary (RAS).

*Modifier auditing*

Compares the CPT/ HCPCS procedure with the billed modifier for clinical appropriateness.

*Mutually exclusive auditing*

Identifies two or more procedures that produce the same clinical result, but are performed by different methods or are procedures that usually are not performed together during the same patient encounter and therefore not allowable for separate reimbursement.

*Pre-Operative and Post-Operative edits*

Identifies E&M services that are reported with surgical procedures during the associated pre/post operative periods. The pre and post operative periods are designated in CMS's National Physician Fee Schedule. If submitting modifier 24, medical notes are required.

*Unbundling auditing*

Identifies billing scenarios where two or more procedures are listed separately when a more accurate comprehensive procedure code exists. The correct codes for the clinical scenario will be allowed and/or automatically added to the claim.

*Unlisted procedure edits*

Identifies procedure codes defined by CPT as unlisted services. Unlisted procedure codes should never be used when a more descriptive procedure code is available.

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## CLAIMS GUIDELINES

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### 3. Claims guidelines

#### A. Submitting a claim

Claims should be submitted to FCHP in one of the following formats:

- Electronic file
- CMS 1500 claim form
- UB-04

Each of these formats is described in detail in #4 below.

Paper claims should be submitted by mail to:

Fallon Community Health Plan  
Claims Department  
P.O. Box 15121  
Worcester, MA 01615-0121

Mail claims for Fallon Preferred Care members to:  
Fallon Community Health Plan  
Claims Department  
P. O. Box 15207  
Worcester, MA 01615-0207

Note that FCHP reserves the right to refuse hand written claims that are incomplete or illegible. Claim forms should be typed or computer generated to insure appropriate processing. For behavioral health, chiropractic, non-emergency dental, and pharmacy claims, see 3-G.

#### B. Referrals and prior authorizations

A referral is a primary care provider (PCP) directed recommendation for a member to see a specialist or travel to a facility that typically falls outside the scope of practice of that provider. The PCP can usually refer a member directly to an in-network specialist without plan approval. In most cases, the member will be referred to a specialist located at, or affiliated with, the hospital or practice group where the PCP normally practices. The PCP may also make arrangements for an ongoing referral to an in-network specialist.

##### *Prior authorization*

If the member and the PCP determine that the type of specialist required is not available within the network, the PCP must receive plan prior authorization from the plan before care is arranged.

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## CLAIMS GUIDELINES

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To ensure reimbursement to specialists and facilities:

- The PCP submits a claim to FCHP for services rendered by entering the PCP name and NPI number in Box 31 and 33.
- The specialist submits a claim to FCHP with evidence of a referral (the PCP's NPI number) from the member's PCP. The following information should be entered on the CMS 1500 or equivalent as evidence:
  - Box 17 – enter referring provider/PCP's name
  - Box 17b – enter referring provider/PCP's NPI number
- For FCHP direct claims submitters
  - Loop 2310A Segment NM1 –enter the referring provider/PCP's name
  - Loop 2310A Segment REF with the G2 qualifier – enter referring provider/PCP's FCHP vendor number
- FCHP's contracted claims clearinghouses have the capability to send the referring provider's FCHP vendor number.
- Failure to include complete referral information (the referring provider's name and NPI number) on the claims will result in a denial.
- Submit request for prior authorization forms on a timely basis. Please submit via fax at 1-508-368-9700.
- Fallon Community Health Plan will not honor retro plan prior authorizations.
- Please note that for services that require authorization, all contracted providers are responsible for ensuring that the appropriate authorization is in place prior to services being rendered. If medically necessary services are rendered to an eligible plan member and there is no prior authorization, the provider will not be reimbursed for related charges and the member may not be billed.
- Follow all referral policies and procedures for Coordination of Benefits (COB), Motor Vehicle Accident (MVA) or workers' compensation cases. For more details, please see 5 – Coordination of Benefits.

Members' coverage for services is subject to their eligibility based on their benefits, contract policies and exclusions.

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## CLAIMS GUIDELINES

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### C. Filing limits

Claims must be received within 120 days of the date of service. If your contract with FCHP specifies a different time limit, that limit may apply. Non-contracted providers must submit claims within 24 months.

Exceptions are as follows:

If...	You should ...
You believed FCHP was the secondary insurer, but we were actually the primary insurer.	Submit a paper claim to FCHP along with the other insurer's Explanation of Benefits (EOB). You must submit within 120 days of the date on the other insurer's EOB. If your contract with FCHP specifies a different time limit, that limit may apply.
The claim is related to a motor vehicle accident.	Submit claims to FCHP after the personal injury protection (PIP) is denied and include copy of PIP letter.
The claim is related to workers' compensation.	Submit claims to FCHP with a copy of the workers' illness/injury compensation insurer's denial.

Written documentation of initial submission of claims filed beyond your filing limit must be provided.

See 9-C for appeals of filing limit issues.

Note: FCHP members cannot be billed for claims denied due to late submission.

### D. Late charges

Late charges will be accepted electronically for Institutional claims provided the claim contains a Bill Type.

*Inpatient:*

Any charge not included on the original inpatient room and board claim should have a bill

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## CLAIMS GUIDELINES

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indicator type of 115 entered in box 4 on the UB-04 form. In addition, the words "late charge" should be typed or written on the claim and should be clearly visible. Only the late charge should be on the claim form. Late charges will be added to the original inpatient claim. For EDI providers, Bill Type should be submitted in Loop 2300 CLM05-1 and CLM05-3.

*Outpatient:*

Any charge not included on the original outpatient claim should have a bill indicator type of 135 entered in box 4 on the UB-04 form. In addition, the words "late charge" should be typed or written on the claim and should be clearly visible. Only the late charge should be on the claim form. Late charges will be added to the original outpatient claim. For EDI providers, Bill Type should be submitted in Loop 2300 CLM05-1 and CLM05-3.

### **E. Covering providers**

When submitting claims to FCHP as a covering provider, the provider must identify him/herself as a covering physician on the CMS 1500 form. The words "covering physician" and the name of the physician you are providing coverage for should be typed or written in box 17. Covering physician claims cannot be accepted electronically; please submit paper claims.

### **F. Balance billing**

Balance billing FCHP members (other than deductibles, copayments or coinsurance) is not allowed for covered services.

### **G. Claims that should not be submitted directly to FCHP**

We contract with outside vendors to provide certain services. Claims for those services should be directed as follows:

BEHAVIORAL  
HEALTH

Behavioral Health claims for providers with behavioral health credentials, should be sent to:  
Beacon Health Strategies  
500 Unicorn Park Drive  
Woburn, MA 01801  
1-888-421-8861

CHIROPRACTIC

Contracted chiropractors should submit claims to:  
Claims Administration  
American Specialty Health Networks  
P.O. Box 509001  
San Diego, CA 92150-9001  
1-800-972-4226

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## CLAIMS GUIDELINES

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Non-contracted chiropractors should submit claims to:  
Fallon Community Health Plan  
ATTN: CLAIMS DEPARTMENT  
PO Box 15121  
Worcester, MA 01615

### NON-EMERGENCY DENTAL

All non-emergency dental services should be submitted to:

Dental Benefit Providers  
ATTN: CLAIMS UNIT  
PO Box 30566  
Salt Lake City, UT, 84130-0566  
1-888-638-0048

### PHARMACY

All contracted retail pharmacies should submit claims electronically to:

CVS/CAREMARK  
1-800-777-1023

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## CLAIMS SUBMISSION

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### 4. Claims submission

#### A. Submitting claims directly to FCHP

FCHP accepts direct submission of Institutional and Professional claims, submitted in the HIPAA-compliant format. Submitting your claims directly to FCHP eliminates the need for a clearinghouse and is offered with no transaction fee.

FCHP offers the following ways to transmit your files: VPN and Secure File Transfer via the Web.

To begin the enrollment process for submitting your claims directly to FCHP, please visit our Web site at [www.fchp.org](http://www.fchp.org), click on the "Physicians & providers" tab and then click on "Electronic data submission," or call our EDI coordinators at 866-275-3247 ext. 69968.

#### B. Submitting claims electronically through an FCHP-contracted clearinghouse

Electronic claim submission offers quicker turnaround time, lower working costs, more efficient payments and a confirmation that claims have been received by the clearinghouse. FCHP's EDI process is secure and HIPAA compliant. Please refer to the Provider Relations Section to review FCHP's Electronic Data Transmission policies and procedures.

The following providers may not file claims electronically:

- Behavioral Health
- Chiropractors
- Dental/oral surgery
- Out-of-area providers

These items cannot be filed electronically:

- Status checks
- Rebills
- Invoiced items (such as supply charges for serum)
- Claims requiring attached documentation
- Coordination of benefit claims

FCHP is contracted with the following clearinghouses:

McKesson

Call 1-800-981-8601 or visit their Web site at  
[www.mckesson.com](http://www.mckesson.com)

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## CLAIMS SUBMISSION

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ProxyMed	Call 1-800-792-5256 option 812. To request an Electronic Claims Enrollment Package or e-mail them at <a href="mailto:provider.enrollment@proxymed.com">provider.enrollment@proxymed.com</a> Carrier code: 01046
Emdeon Corporation™	(formerly known as WebMD) Call 1-800-845-6592 or visit their Web site: <a href="http://www.emdeon.com">www.emdeon.com</a> Carrier code: 22254

**You must enroll with one of the above contracted clearinghouses prior to claims submission.**

When submitting claims electronically through either a clearinghouse or directly to FCHP:

- Providers must submit claims using their assigned NPI number.
- You must notify FCHP and the clearinghouse if your practice information changes (e.g., tax number, address changes).
- New providers in your practice must be enrolled with the clearinghouse, credentialed and contracted by FCHP.
- Membership number (Membership number is the 13-digit number on each membership card. The number will look similar to this: 88882345678\*01. You must transmit all 13 of the numbers without the asterisk; example: 8888234567801. The suffix is also required to identify the patient's date of birth, full name and address must be entered correctly. If a claim contains an invalid or improper membership number, the wrong date of birth, or a misspelled name it may not file in our system.
- Submit exact names as indicated on the membership card (no nicknames or hyphenated names).
- If you are submitting for services that took place in different settings (e.g., office, outpatient, ER) a separate claim must be submitted for the office visit, the outpatient visit and the ER visit. We cannot process claims when multiple places of service are billed.

For more information contact one of our EDI coordinators at 1-866-ASK-FCHP (1-866-275-3247) ext. 69968 or e-mail at [edi.coordinator@fchp.org](mailto:edi.coordinator@fchp.org)

### C. Using the CMS 1500 claim form

The CMS 1500 claim form should be used for billing all professional services rendered by the following:

- Independent providers

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## CLAIMS SUBMISSION

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- Hospital-based physicians
- Laboratories
- Radiology groups
- Emergency physician groups
- Ambulance companies
- DME providers
- Early intervention services
- Medical supply vendors
- Pharmacy
- Physical, speech, occupational therapists

When submitting a claim:

- Do not bill future dates of service.
- Do not bill for two or more places of service on one claim. FCHP is unable to process with different places of service.
- Use appropriate modifiers, up to four when necessary.
- Claims should be submitted for complete length of service. Interim billing is not accepted.
- Unlisted CPT/HCPCS codes must have documentation attached.
- Surgical claims exceeding \$1,000 must have operative notes attached.
- Per CMS guidelines, unique physician identification numbers are required. Please submit in box #33 of the CMS 1500 form.

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## CLAIMS SUBMISSION

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Follow the guidelines below when submitting a CMS 1500 claim form to Fallon Community Health Plan. The “Required” column indicates if a specific field is required by FCHP or is optional.

For specific fields required for EDI claim submission, refer to our companion guide: Health Care Claims Submission X12N 837 (Version 4010) Implementation Guide—Professional at <http://www.fchp.org/providers/provider-tools/edi-companion-guides.aspx>.

Place of service codes (line 24-B) and modifiers (line 24-D) are listed in the reference section of this manual.

Box #	Field name	Required	Instructions
1–13 - Patient and insured information			
1	Type of health insurance	Optional	Show type of health insurance coverage applicable to this claim by checking the appropriate boxes.
1a	Insured’s ID number	YES	Enter FCHP 13-digit membership number as indicated on the membership card.
2	Patient’s name	YES	Enter patient’s last name, first name and middle initial as name appears on card.
3	Patient’s birth date and sex	YES	Enter patient’s eight-digit birth date (MMDDYYYY) and sex (M or F).
4	Insured’s name	YES	Enter policyholder’s last name, first name, middle initial as name appears on card. If patient and insured are the same, enter “Same.”

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
5	Patient's address	YES	Enter patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.
6	Patient relationship to insured	YES	Check the appropriate box for patient's relationship to the insured.
7	Insured's address	YES	Enter insured's address and telephone number. When address is the same as the patient's, enter the word "Same." Complete this box only when boxes 4 and 11 are completed.
8	Patient status	YES	Check the appropriate box for patient's marital status and whether employed or a student.
9	Other insured's name	YES	Enter last name, first name, and middle initial of the insured if it is different from that entered in box 4. If the same, enter the word "Same."
9a	Other insured's policy	YES	Enter policy or group number of the other insured's or group number health insurance policy.
9b	Other insured's date of birth	YES	Enter other insured's date of birth (MMDDYYYY) and sex.

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
9c	Employer name or school	Optional	Enter other insured's employer's name or school name.
9d	Insurance plan name or program name	Optional	Enter other insured's insurance plan name. Attach an <i>Explanation of Benefits</i> from the primary insurer to the claim.
10	Is patient's condition related to: a. Employment? (current or previous) b. Auto accident? c. Other accident?	YES	Check "YES" or "NO" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in item 24. Enter State postal code. Any item checked "YES" indicates there may be other insurance primary. Identify primary insurance information in item 11.
10d	Reserved for local use	NO	Not applicable to FCHP
11	Insured's policy group or FECA number	YES	If the patient has other insurance, enter the policy number.
11a	Insured's date of birth	YES	Enter insured's date of birth (MMDDYYYY) if different from box 3.
11b	Employer name or school name	YES	Enter employer's name or school name if applicable.

**CLAIMS SUBMISSION**

Box #	Field name	Required	Instructions
11c	Insurance plan name or program name	YES	Enter insurance plan or program name, if applicable.
11d	Is there another health benefit plan?	YES	Check YES or NO to indicate if there is or if there is not any other health insurance.
12	Patient's or authorized person's signature	Optional	The patient or authorized representative must sign and date unless their signature is on file. In lieu of signing the claim, patient may sign a statement to be retained in provider, physician or supplier file. If an authorized person signs the form, the statement's signature line must indicate patient's name followed by "by" and representative's name, address, relationship to patient and reason the patient cannot sign.
13	Insured's or authorized person's signature	Optional	The insured's or authorized person's signature authorizes payment of benefits to participating provider or supplier.
14	Date of current illness, injury or pregnancy	YES	Enter eight-digit date (MMDDYYYY) current illness, injury or pregnancy.
15	If patient has had same or similar illness, give first date	Optional	Enter first date. (MMDDYYYY)

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
16	Dates patient unable to work in current occupation	Optional	Enter dates (MMDDYYYY) patient is unable to work in current occupation. An entry in this field may indicate employment-related insurance coverage.
17	Name of referring, covering provider or other source	YES	<p>Enter last name, first name and middle initial of referring or ordering provider if service or item was ordered or referred by a physician.</p> <p><i>Referring physician:</i> A physician who requests an item or service for the beneficiary for which payment may be made by FCHP.</p> <p><i>Covering physician:</i> A physician providing coverage on behalf of the patient's primary care physician.</p> <p><i>Ordering physician:</i> A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services or durable medical equipment.</p>
17a	ID number of referring physician	Optional	Enter FCHP provider ID number of the referring physician or ordering physician for ancillary services. To obtain this number, contact Provider Relations at 866-ASK-FCHP (866-275-3247)

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
17b	NPI number of referring physician	YES	Enter NPI number of the referring physician or ordering physician for ancillary services.
18	Hospitalization dates related to current services	YES	Enter date (MMDDYYYY) when medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	NO	Not applicable
20	Outside lab	Optional	Indicate if laboratory work was performed outside the physician's office. If YES, indicate which tests and the associated costs.
21	Diagnosis or nature of illness or injury	YES	Enter appropriate ICD-9-CM diagnosis code to indicate patient's diagnosis or condition. Enter up to four codes in priority order beginning with the primary. Codes listed must be complete ICD-9-CM diagnosis codes carried out to the fourth or fifth digit.
22	Medicaid resubmission code	NO	Not applicable
23	Prior authorization	YES	Enter FCHP preauthorization number, if applicable.

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
	number		
24a	Dates of service	YES	Enter date (MMDDYYYY) for each procedure, service or supply. When billing a consecutive date range, please do not bill future dates of service.
24b	Place of service	YES	Enter appropriate CMS place of service code from the list provided in the reference section of this manual.
24c	Type of service	NO	Not applicable.
24d	Procedures, services or supplies	YES	Enter appropriate CPT4, HCPCS Level II or ADA codes. CPT codes are required for all professional claims. When applicable, use the appropriate modifier, up to four. The modifier that affects payment must be submitted first.
24e	Diagnosis code	YES	Enter diagnosis code reference number as shown in item 21, to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, enter the primary diagnosis code for each service.

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
24f	\$ Charges (Dollar amount of charges)	YES	Enter charge for each listed service.
24g	Days or units	YES	Enter number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. 1 unit of anesthesia = 15 minutes. If only one service is performed, the numeral 1 must be entered.
24h	EPSDT Family Plan	NO	Not applicable.
24i	ID Qualifier	NO	Not applicable.
24j	Rendering provider ID NPI number	YES	Enter rendering provider NPI number.
25	Federal tax ID number	YES	Enter service provider or supplier federal tax ID (employer identification number) or Social Security number.
26	Patient's account number	Optional	Enter patient's account number assigned by service provider's or supplier's accounting system. This field is optional to assist you in patient identification. The account number will appear on your <i>Remittance Advice Summary (RAS)</i> .

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
27	Accept assignment?	YES	Check appropriate block to indicate whether the provider of service or supplier accepts assignment for the claim. By checking Yes, physician agrees to accept the amount paid by the third party as payment in full.
28	Total charge	YES	Enter total charges for the services (i.e., total of all charges in item 24f).
29	Amount paid	YES	If applicable, enter amount of payment received from another insurance carrier prior to submitting claim to FCHP.
30	Balance due	YES	Enter balance due. (box 28 minus box 29)
31	Signature of physician or supplier including degrees or credentials	YES	Enter signature and typed name of physician/supplier and the date the form was signed. Only one provider of service allowed per claim.
32	Name and address of facility where services were rendered	YES	Enter facility name, address if services were furnished in a hospital, clinic, laboratory or facility other than patient's home or physician's office, and NPI number.

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
33	Physician's supplier's billing name, address, zip code and phone	YES	Enter service provider's or supplier's billing name and NPI number, address, zip code and telephone number identifying where payments should be sent.

Source: Centers for Medicare and Medicaid Services, Health Insurance Claim Form – CMS 1500

# CLAIMS SUBMISSION

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>					
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM   DD   YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)							
CITY			STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE					
ZIP CODE			TELEPHONE (Include Area Code) ( )			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code) ( )					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM   DD   YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____ DATE _____							
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM</b>															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____						14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM   DD   YY						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. RESERVED FOR LOCAL USE						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/PCS   MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF EPROT Family Plan	H. ID. QJAL	I. RENDERING PROVIDER ID #					
1										NPI					
2										NPI					
3										NPI					
4										NPI					
5										NPI					
6										NPI					
26. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b. _____							

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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## CLAIMS SUBMISSION

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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

### REFERS TO GOVERNMENT PROGRAMS ONLY

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

### BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

### SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

### NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the *Federal Register*, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," *Federal Register* Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

### MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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**CLAIMS SUBMISSION**

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**D. Billing and payment guidelines for professional claims**

All professional covered services, unless otherwise specifically stated in your contract, will be paid at the lesser of your billed charges or the contracted rate minus any applicable copayments, coinsurance and/or deductibles.

Topics	Billing and payment guidelines
Ambulance	<ul style="list-style-type: none"> <li>• Origin and destination modifiers are required on all CMS 1500 claim forms.</li> <li>• Refer to the modifier listings in the reference section of the manual for further details.</li> <li>• Hospitals should bill ambulance services separately from outpatient services.</li> <li>• Claims should be submitted with HCPCS transportation codes A0021 – A0999.</li> </ul>
Anesthesia	<ul style="list-style-type: none"> <li>• Anesthesia claims must be submitted with CPT codes in the 00100-01999 range.</li> <li>• Providers are required to report the total anesthesia time in minutes in field 24g of the claim form. Also include the start and end time (i.e., 11:15 a.m. – 12:45 p.m.). Time units are determined on the basis of one time unit for every 15 minutes of anesthesia. Anesthesia time is defined by the continuous actual presence of the anesthesiologist (or CRNA).</li> <li>• All anesthesia codes require a modifier:               <ul style="list-style-type: none"> <li>○ AA - performed personally</li> <li>○ AD - medical supervision by a physician: more than four concurrent anesthesia procedures</li> <li>○ QK - medical direction of two, three or four concurrent procedures</li> <li>○ QY - medical direction of one CRNA by an anesthesiologist</li> </ul> </li> <li>• Certified Registered Nurse Anesthetist (CRNA) should bill with modifiers:               <ul style="list-style-type: none"> <li>○ QX - CRNA service with medical direction by a physician</li> <li>○ QZ - CRNA service without medical direction by a</li> </ul> </li> </ul>

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**CLAIMS SUBMISSION**

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Topics	Billing and payment guidelines
	<p style="text-align: center;">physician</p> <ul style="list-style-type: none"> <li>• No modifiers or time is required on pain management services. These encounters should be submitted using the appropriate CPT-4 code and appropriate units in field 24g. Please do not bill the base units in field 24g. Example: code 62319-nerve block. This code may be used for the first day of pain management. For the following days, procedure code 01996 should be used.</li> <li>• We recognize that anesthesiologists perform non-anesthesia type procedures such as intubation, central venous access and consultations. These encounters should be submitted using the appropriate CPT-4 code and one unit in field 24g.</li> <li>• The reporting of physical status modifiers (P1–P6) and qualifying circumstances (99100 – 99140) does not affect reimbursement; please note some contract provisions may vary.</li> </ul>
Behavioral Health	<p>All behavioral health professional visits should be submitted to:</p> <p style="padding-left: 40px;">Beacon Health Strategies 500 Unicorn Park Drive Woburn, MA 01801</p> <p>Behavioral health claims for the members listed below should be mailed to:</p> <p style="padding-left: 40px;">Fallon Community Health Plan Claims Department P.O. Box 15207 Worcester, MA 01615-0207</p> <p style="padding-left: 40px;">Summit ElderCare Hospice Companion Care Fallon Preferred – members who reside outside of MA Fallon Senior Preferred - members who reside outside of MA</p>

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines
Chiropractic Services	<p>All chiropractic services should be submitted to:</p> <p style="padding-left: 40px;">Claims Administration American Specialty Health Networks P.O. Box 509001 San Diego, CA 92150-9001</p> <p>A copy of the prescription must be included with the initial claim submission to ASHN.</p> <p>Chiropractic health claims for Fallon Preferred Care members should be mailed to:</p> <p style="padding-left: 40px;">Fallon Community Health Plan Claims Department P.O. Box 15207 Worcester, MA 01615-0207</p>
Drugs Excluding Oral (HCPCS codes)	<ul style="list-style-type: none"> <li>• May require itemized invoice depending on contract to be submitted with the claim to ensure appropriate reimbursement of injectable/pharmacy material.</li> </ul>
Durable Medical Equipment	<p>Do not bill future dates of service. Use appropriate HCPCS codes as follows:</p> <ul style="list-style-type: none"> <li>• Orthotics: L0100–L4398</li> <li>• Prosthetics: L5000–L9900</li> <li>• DME: K0001–K0730 E0100–E8002</li> </ul> <p>Use the appropriate modifiers as necessary. Unlisted HCPCS codes require pre-authorization and must be submitted with supporting documentation.</p>
Early Intervention	<p>Claims should be billed with the state-mandated HCPCS codes:</p> <p><b>H2015</b> Comprehensive community support services per 15 minutes</p> <p><b>T1015</b></p>

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines
	<p>Clinic visit/encounter all-inclusive</p> <p><b>T1023</b> Screening to determine the appropriateness of consideration for individual participation in a specified program, project or treatment, per encounter</p> <p><b>T1024</b> Evaluation and treatment by an integrated specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter</p> <p><b>T1027</b> Family training and counseling for child development, per 15 minutes</p> <p><b>96153</b> Health and behavior intervention, each 15 minutes, face to face: group</p> <ul style="list-style-type: none"> <li>• All early intervention services require one of the following modifiers to indicate services provided by or level of care:</li> </ul> <p style="margin-left: 40px;">                     AH – Clinical psychologist                      AJ – Clinical social worker                      GN – Speech/Language therapist                      GO – Occupational therapist                      GP – Physical therapist                      HN – Developmental specialist                      TD – Registered nurse                      TE – Licensed practical nurse                      TL – Individualized family plan                      U1 – Level of care defined by the state                      U2 – Level of care defined by the state                 </p> <p>The name of the party providing services, including their credentials, must be listed in Box 31 of the CMS 1500 claim form.</p>
EPDST Service: Medical Protocol and Periodicity Schedule	<p>You can find the EPDST Service: Medical Protocol and Periodicity Schedule at:</p> <p><a href="http://www.mass.gov/Eeohhs2/docs/masshealth/providermanual/appx-w-all.pdf">http://www.mass.gov/Eeohhs2/docs/masshealth/providermanual/appx-w-all.pdf</a></p>

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines																														
<p>EPSDT/PPHSD Screening Service Codes</p>	<p>The following services are payable in addition to the initial, periodic, or interperiodic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Preventive Pediatric Health-care Screening and Diagnosis (PPHSD) visit when they are performed and interpreted in the office of the provider who furnished the visit.</p> <p><b>Laboratory Services</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Service Code</th> <th style="text-align: left;">Description</th> </tr> </thead> <tbody> <tr> <td>81000</td> <td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity urobilinogen, any number of these constituents; non-automated with microscopy,</td> </tr> <tr> <td>81002</td> <td>non-automated, without microscopy</td> </tr> <tr> <td>84703</td> <td>Gonadotropin, chorionic (hCG); qualitative</td> </tr> <tr> <td>85013</td> <td>Blood count; spun microhematocrit</td> </tr> <tr> <td>85014</td> <td>Blood count; hematocrit (Hct)</td> </tr> <tr> <td>85018</td> <td>Blood count; hemoglobin (Hgb)</td> </tr> <tr> <td>86580</td> <td>Skin test, tuberculosis, intradermal</td> </tr> <tr> <td>87081</td> <td>Culture, presumptive, pathogenic organisms, screening only</td> </tr> <tr> <td>87210</td> <td>Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)</td> </tr> </tbody> </table> <p><b>Audiometric Hearing Function Tests</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><i>Service Code</i></th> <th style="text-align: left;"><i>Description</i></th> </tr> </thead> <tbody> <tr> <td>92551</td> <td>Screening test, pure tone, air only</td> </tr> <tr> <td>92552</td> <td>Pure tone audiometry (threshold); air only</td> </tr> <tr> <td>92587</td> <td>Evoked otoacoustic emissions, limited (single stimulus level, either transient or distortion products)</td> </tr> </tbody> </table> <p><b>Behavioral Health Screening</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><i>Service Code</i></th> <th style="text-align: left;"><i>Description</i></th> </tr> </thead> <tbody> </tbody> </table>	Service Code	Description	81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity urobilinogen, any number of these constituents; non-automated with microscopy,	81002	non-automated, without microscopy	84703	Gonadotropin, chorionic (hCG); qualitative	85013	Blood count; spun microhematocrit	85014	Blood count; hematocrit (Hct)	85018	Blood count; hemoglobin (Hgb)	86580	Skin test, tuberculosis, intradermal	87081	Culture, presumptive, pathogenic organisms, screening only	87210	Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)	<i>Service Code</i>	<i>Description</i>	92551	Screening test, pure tone, air only	92552	Pure tone audiometry (threshold); air only	92587	Evoked otoacoustic emissions, limited (single stimulus level, either transient or distortion products)	<i>Service Code</i>	<i>Description</i>
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**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines
	<p>96110 Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. Please refer to the use of modifiers and proper billing procedure for this code in the tables below.</p> <p><b>Vision Tests</b></p> <p><i>Service Description</i> <i>Code</i></p> <p>99173 Screening test of visual acuity, quantitative, bilateral</p> <p><b>Add-on service code</b></p> <p>Periodic visits delivered according to the EPSDT Services: Medical Protocol and Periodicity Schedule (FCHP Provider Manual), and interperiodic visits at which all the screenings required by the EPSDT Services: Medical Protocol and Periodicity Schedule (FCHP Provider Manual) are delivered may be claimed with an add-on code.</p> <p><b>S0302</b> Completed Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Service (list in addition to code for appropriate evaluation and management service. The add-on code may be applied only to codes 99381-99385 and 99391-99395, and may be used for EPSDT services and PPHSD services.)</p> <ul style="list-style-type: none"> <li>• List the preventive medicine evaluation and management code (99381-99385 or 99391-99395) and the S0302 code on separate lines.</li> <li>• FCHP S0302 code reimbursement rate for a contracted provider reimbursement is based upon the provider’s contracted agreement and for non-contracted providers, reimbursement is based upon the current MassHealth published rates for non-contracted providers.</li> </ul> <p><b>How to Claim for the Standardized Behavioral Health Screening Tools</b></p> <p>FCHP will pay for the administration and scoring of the behavioral health tools listed in the EPSDT/PPHSD Services: Medical Protocol and Periodicity Schedule (FCHP Provider Manual) when administered by:</p>

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines									
	<ul style="list-style-type: none"> <li>• Physicians</li> <li>• Nurse practitioners, and physician assistants under a physician’s supervision</li> </ul> <p>FCHP will reimburse for the administration of one standardized behavioral health screening tool per FCHP MassHealth member, per day, regardless of the number of behavioral health screening tools administered on the same day for a given member.</p> <p>Payment will be made to Primary Care Providers for the administration and scoring of the behavioral health screening tools in accordance with the EPSDT Periodicity Schedule. The provision of these services is considered separate from, and in addition to, the provision of periodic or interperiodic EPSDT and PPHSD visits. Primary Care Provider reimbursement will be made in accordance with his/her FCHP Provider Agreement. Claims for the behavioral health screening tool must be submitted using Current Procedural Terminology (CPT) service code 96110 (EPSDT/PPHSD Screening Services Codes).</p> <p>The following provider types can submit claims for reimbursement for the standardized behavioral health screening tools:</p> <ul style="list-style-type: none"> <li>• Physicians</li> <li>• Hospital outpatient departments</li> </ul> <p>Please note that <b>distinct modifiers are required</b> when billing the CPT code for the behavioral health screening tools. Effective July 1, 2011, failure to include the modifier will result in denial of the claim. These <b>modifiers</b> will allow FCHP to track the disposition of the screening so that FCHP will know the number of FCHP MassHealth members with a behavioral health need identified. These modifiers vary by provider type. Please see Table 1, <i>“Modifiers for Use with CPT Code 96110,”</i> for direction on the appropriate modifier to use.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: left;">Table 1. Modifiers for Use with CPT Code 96110</th> </tr> <tr> <th style="width: 33%;">Servicing Provider</th> <th style="width: 33%;">Modifier for Use When No Behavioral Health Need Identified *</th> <th style="width: 33%;">Modifier for Use When Behavioral Health</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </tbody> </table>	Table 1. Modifiers for Use with CPT Code 96110			Servicing Provider	Modifier for Use When No Behavioral Health Need Identified *	Modifier for Use When Behavioral Health			
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**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines														
			<b>Need Identified *</b>												
	Physician, Outpatient Hospital Department (OPD)	U1	U2												
	Nurse Practitioner employed by Physician	U5	U6												
	Physician Assistant employed by Physician	U7	U8												
	<p>* Behavioral health needs includes needs in the area of behavioral health, social-emotional well-being, or mental health.</p> <p>The text of the CPT code and modifiers required to claim for the standardized behavioral health screening tools are listed in Table 2, <i>“Text of CPT Code and Modifiers for Claiming the Standardized Behavioral Health Screening Tools.”</i> Please note that this list of codes is for your information only. <b>The codes and modifiers that are required to claim for the administration and scoring of the behavioral health screening tool.</b></p> <p><b>Table 2. Text of CPT Code and Modifiers for Claiming the Standardized Behavioral Health Screening Tools</b></p> <table border="1"> <thead> <tr> <th style="background-color: #cccccc;">Code/Modifier</th> <th style="background-color: #cccccc;">Text of Code/Modifier</th> </tr> </thead> <tbody> <tr> <td>CPT 96110</td> <td>Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report</td> </tr> <tr> <td>U1</td> <td>Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening with no behavioral health need identified</td> </tr> <tr> <td>U2</td> <td>Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening and behavioral health need identified</td> </tr> <tr> <td>U5</td> <td>Nurse Practitioner (SA) employed by Physician, completed behavioral health screening with no behavioral health need identified</td> </tr> <tr> <td>U6</td> <td>Nurse Practitioner (SA) employed by Physician, completed behavioral health screening and behavioral health need identified</td> </tr> </tbody> </table>			Code/Modifier	Text of Code/Modifier	CPT 96110	Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	U1	Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening with no behavioral health need identified	U2	Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening and behavioral health need identified	U5	Nurse Practitioner (SA) employed by Physician, completed behavioral health screening with no behavioral health need identified	U6	Nurse Practitioner (SA) employed by Physician, completed behavioral health screening and behavioral health need identified
Code/Modifier	Text of Code/Modifier														
CPT 96110	Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report														
U1	Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening with no behavioral health need identified														
U2	Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening and behavioral health need identified														
U5	Nurse Practitioner (SA) employed by Physician, completed behavioral health screening with no behavioral health need identified														
U6	Nurse Practitioner (SA) employed by Physician, completed behavioral health screening and behavioral health need identified														

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines				
	<table border="1"> <tr> <td style="text-align: center;">U7</td> <td>Physician Assistant (HN) employed by Physician, completed behavioral health screening with no behavioral health need identified</td> </tr> <tr> <td style="text-align: center;">U8</td> <td>Physician Assistant (HN) employed by Physician, completed behavioral health screening and behavioral health need identified</td> </tr> </table>	U7	Physician Assistant (HN) employed by Physician, completed behavioral health screening with no behavioral health need identified	U8	Physician Assistant (HN) employed by Physician, completed behavioral health screening and behavioral health need identified
U7	Physician Assistant (HN) employed by Physician, completed behavioral health screening with no behavioral health need identified				
U8	Physician Assistant (HN) employed by Physician, completed behavioral health screening and behavioral health need identified				
Eye Care	<p>When billing for routine eye exams to FCHP please use the following codes*:</p> <ul style="list-style-type: none"> <li>• S0620 - Routine ophthalmologic exam - new patient</li> <li>• S0621 - Routine ophthalmologic exam - established patient</li> </ul> <p>* CPT codes 92002, 92004, 92012 and 92014 are not interchangeable with HCPCS codes S0620 and S0621. Therefore, codes 92002, 92004, 92012 and 92014 will not be reimbursed under the benefit and guidelines for routine eye exams.</p>				
Eye glass frames	<p>When billing for eyeglass frames to FCHP please use the following codes:</p> <ul style="list-style-type: none"> <li>• V2020 – Standard frame</li> <li>• V2025 – Deluxe frame</li> </ul> <p>*Please bill the code for the frame with the full amount on one claim line indicating one unit for each pair of frames dispensed. Do not bill on 2 claim lines using both codes when one frame is dispensed.</p>				
Injectables	<ul style="list-style-type: none"> <li>• See Drugs excluding oral (HCPCS codes)</li> <li>• See Vaccines</li> </ul>				
Laboratory	<ul style="list-style-type: none"> <li>• Claims should be submitted with CPT/HCPCS industry standard codes.</li> <li>• Claims must be submitted with the appropriate diagnosis code.</li> <li>• The referring physician should be listed in Box 17 of the CMS 1500 claim form.</li> </ul>				

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## CLAIMS SUBMISSION

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Topics	Billing and payment guidelines
Nurse Midwife	<ul style="list-style-type: none"> <li>• Payment for Nurse Midwife services is made only to the Nurse Midwife or his or her employer.</li> <li>• Nurse Midwives are required to submit claims with their own billing identification numbers for their professional services rendered.</li> <li>• The Nurse Midwives NPI number must be submitted in item 33 of the CMS 1500 claim form. In a group setting, this number is reported in item 24j and the group NPI number in item 33.</li> <li>• Nurse Midwives must use the SB modifier to report <b>services</b> provided independently. Nurse Midwives should use reduced service modifiers to report when they have not provided all the services covered by a global allowance.</li> <li>• Do not use SB modifier on claim line for reporting of contraceptives such as J7300.</li> <li>• Nurse Midwives must abide by the same requirements as FCHP contracted physicians.</li> </ul>
Nurse Practitioner	<ul style="list-style-type: none"> <li>• Direct payment may be made to the NP or to the employer or contractor of the NP. NPs are required to submit claims with their own billing identification numbers for their professional services rendered.</li> <li>• The NP's NPI number must be submitted in item 33 of the CMS 1500 claim form. In a group setting, this number is reported in item 24j and the group NPI number in item 33.</li> <li>• NP assistant at surgery claims will be paid to their employing physician or group. Add modifier AS to the surgery procedure code and indicate the NP's NPI number on the claim in item 24j of the CMS 1500 claim form.</li> <li>• Ordering and referral services are included in the payment for services performed. No separate payment is made for ordering or referring services.</li> <li>• NPs must abide by the same preauthorization requirements as FCHP contracted physicians.</li> </ul>

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**CLAIMS SUBMISSION**

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Topics	Billing and payment guidelines
OB Global Care	<p>Global obstetrical reimbursement refers to the policy of paying a single-case rate for bundled maternity services. This includes antepartum care, delivery and postpartum care. Multiple vaginal or multiple cesarean deliveries are reimbursed under a single global payment. Bill for pregnancy exam/test using ICD-9-CM code V22.0 or V22.1. Initial exam/test is included in the global obstetric reimbursement.</p> <ul style="list-style-type: none"> <li>• If physician provides all or part of the antepartum/prenatal or postpartum patient care, but does not perform the delivery, claims should be submitted using the following guidelines:</li> <li>• 1 to 3 antepartum care visits performed: bill the appropriate evaluation and management code and diagnosis.</li> <li>• 4 to 6 antepartum care visits performed: bill with CPT code 59425 (antepartum care only: 4 to 6 visits). This code should be billed as one unit of service.</li> <li>• 7 or more antepartum visits performed: bill with CPT code 59426 (antepartum care only: 7 or more visits). This code should be billed as one unit of service. If physician performs delivery only, submit claims using the following guidelines:</li> <li>• Services should be billed with CPT code 59409 for vaginal delivery only.</li> <li>• Services should be billed with CPT code 59514 for cesarean delivery only.</li> </ul>
Pathology	<ul style="list-style-type: none"> <li>• Claims should be billed with CPT/HCPCS industry standard codes.</li> <li>• Claims must be submitted with the appropriate diagnosis code.</li> <li>• The referring physician should be listed in Box 17 of the CMS 1500 claim form.</li> </ul>

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**CLAIMS SUBMISSION**

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Topics	Billing and payment guidelines
Physical Therapy	<ul style="list-style-type: none"> <li>• Each date of service must be reported individually.</li> <li>• Claims should be submitted with CPT codes in the 97001–97799 range.</li> <li>• The following CPT codes should be used for the initial visits:               <ul style="list-style-type: none"> <li>○ 97001 - physical therapy evaluation</li> <li>○ 97003 - occupational therapy evaluation</li> <li>○ 92506 - speech therapy evaluation</li> </ul> </li> </ul>
Physician Assistant	<ul style="list-style-type: none"> <li>• Payment for services of a PA will be made only to the actual employer of the PA.</li> <li>• The employer may be a physician, medical group, professional corporation, hospital, skilled nursing facility or nursing facility. An ambulatory surgical center is not an acceptable employer.</li> <li>• The claim must have the employing physician or group’s name, address and NPI number in item 33 of the CMS 1500 claim form.</li> <li>• PA assistant at surgery claims will be paid to their employing physician or group. Add modifier AS to the surgery procedure code and indicate the PA NPI number on the claim in item 24j of the CMS 1500 claim form.</li> <li>• When PAs are ordering or referring services, they must submit their name and NPI number in item 17 and 17b of the CMS 1500 claim form.</li> <li>• PAs must abide by the same preauthorization requirements as the FCHP contracted physicians.</li> </ul>
Radiology	<ul style="list-style-type: none"> <li>• Claims should be billed with CPT/HCPCS industry standard codes.</li> <li>• Claims must be submitted with the appropriate diagnosis code.</li> <li>• The referring physician should be listed in Box 17 of the CMS 1500 claim form.</li> <li>• Modifiers should be used to indicate technical or professional services. Refer to the modifier listings in the Reference section of this manual for further details.</li> <li>• When reporting (bilateral) radiological services you should use</li> </ul>

## CLAIMS SUBMISSION

Topics	Billing and payment guidelines
	<p>the –RT and –LT modifiers. Radiological services should be billed on two claim lines with the –RT and –LT modifier and one unit on each line. Do not use the –RT and –LT modifier to report services already identified as bilateral by definition.</p>
Reciprocal Billing/ Locum Tenens Arrangements	<ul style="list-style-type: none"> <li>• The reciprocal provider and locum tenens are responsible for adhering to the same FCHP’s policies and procedures as the absentee physician.</li> <li>• The absentee physician may submit the claim and receive payment for part B covered arrangements services under Locum Tenens and/or reciprocal billing arrangements.</li> <li>• Services of a substituting physician are identified by entering modifier Q5 or Q6 in item 24d of the CMS 1500 claim form.</li> <li>• The NPI number of the substituting physician must be reported on the claim submitted by the billing “absentee” physician in item 23 on the CMS 1500 claim form.</li> <li>• The billing “absentee” physician’s NPI number must be reported in item 33 on the CMS 1500 claim form for a solo practice and item 24j on the CMS 1500 claim form for group practice arrangements.</li> </ul>
Surgical Global	<ul style="list-style-type: none"> <li>• Attach operative notes for all surgery submissions over \$1,000.</li> <li>• Providers should submit each encounter to record rendered services.</li> <li>• Use code 99024 when reporting postoperative care that is reimbursed within the global allowance. Providers are permitted to collect applicable copayment for services billed within the global period.</li> <li>• Use -51 modifier to indicate that more than one surgical service was performed. Reimbursement for second through fifth surgical service will be at 50% of the billing physician’s contracted rate in accordance with Medicare guidelines.</li> <li>• When separate payment is requested within the post-op period because the services are unrelated to the diagnosis for which the</li> </ul>

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines
	<p>surgery was performed, the appropriate E/M code with a -24 modifier and supporting documentation must be submitted.</p>
Vaccines	<ul style="list-style-type: none"> <li>• FCHP does not reimburse for the cost of vaccines that are available free of charge by the Massachusetts Department of Public Health Immunization Program.</li> <li>• When billing a supplied vaccine, append the SL modifier to the appropriate vaccine CPT code.</li> <li>• Preauthorization is not required for vaccines, with the exception of unlisted vaccine/toxoids submitted with CPT code 90749.</li> <li>• When there is a documented shortage of a state-supplied vaccine, FCHP will reimburse providers who have purchased vaccines. When billing for vaccines in the event of a shortage, bill the appropriate vaccine CPT code. You should not append the SL modifier in this scenario.</li> <li>• An invoice must be submitted with claims for those vaccinations not supplied by the Massachusetts Department of Public Health Immunization Program.</li> <li>• Use codes 90465–90474 for reporting and for reimbursement of the administration of vaccines.</li> <li>• Minimal office visit procedure 99211 will be denied with the administration of drug procedure 90465–90474 guidelines.</li> </ul> <p><i>Flu Vaccine:</i> (No invoice required)</p> <ul style="list-style-type: none"> <li>• If administered on the same day as a physician service is performed, use code 90471 to report the administration of the vaccine.</li> </ul>

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**CLAIMS SUBMISSION**

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Topics	Billing and payment guidelines
	<ul style="list-style-type: none"><li>• If purchased, bill codes 90655, 90656, 90657, 90658 or 90660 and G0008 for the administration.</li><li>• If obtained through the state, bill with codes 90655, 90656, 90657, 90658, or 90660 with a SL modifier, and charge of \$0.00, and the code G0008 for the administration.</li></ul>

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## CLAIMS SUBMISSION

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### E. Using the UB-04 claim form

The UB-04 claim form should be used for billing all technical services rendered by the following:

- Hospital inpatient services.
- Hospital outpatient and emergency department services. Outpatient services include day surgery, observation bed status, PT, OT, ST and ancillary testing.
- Skilled nursing facility.
- Surgery services.
- VNA services/Home Health Care services.

When submitting a claim:

- Use the appropriate revenue and CPT/HCPCS codes.
- Unlisted CPT/HCPCS codes must have documentation attached.
- Do not bill for future dates of service.
- DRG-related inpatient claims should have the appropriate DRG listed on the UB-04 claim form in box 84.
- Include itemization for inpatient claims to be paid on a percent of charges for claims \$25,000 or greater. (Per diem and case payments excluded.)

When submitting a claim for late charges:

- In box 4 of the UB-04 claim form, a bill indicator of 115 (inpatient claims) or 135 (outpatient claims) must be used to indicate that the claim is for late charges.
- Late charges will be accepted electronically for Institutional claims provided the claim contains a Bill Type. For EDI providers, Bill Type should be submitted in Loop 2300 CLM05-1 and CLM05-3.
- Only the late charge should be submitted on the claim.
- No charges previously submitted should be billed.
- Late charges will be added to the original claim.

Follow the guidelines below when submitting a UB-04 claim form to Fallon Community Health Plan. The "Required" column indicates if a specific field is required by FCHP or is optional.

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## CLAIMS SUBMISSION

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For specific fields required for EDI claim submission, refer to our companion guide: Health Care Claims Submission X12N 837 (Version 4010) Implementation Guide—Institutional at <http://www.fchp.org/providers/provider-tools/edi-companion-guides.aspx>.

Many codes are required on a UB-04 claim form. For a complete listing of UB-04 codes go to the CMS Web site.

Box #	Field name	Required	Instructions
1	Provider name, address and telephone number	YES	Enter name, address and telephone number of the hospital, surgery center or VNA.
2	Pay to name	Optional	Not applicable to FCHP.
3a	Patient control number	Optional	Enter patient account number assigned by the provider. This information can be used to facilitate payment posting.
3b	Medical record number	Optional	
4	Type of bill	YES	Enter three-digit code indicating type of bill being submitted. The first digit identifies type of facility. The second classifies type of care. The third indicates sequence of this bill in this particular episode of care, known as the frequency code. Use 135 - To submit an outpatient charge not included on original bill. Use 115 - To submit an inpatient charge not included on original bill. For the list of complete codes go to the CMS Web site.
5	Federal tax number	YES	Enter federal tax ID number.
6	Statement covers period	YES	Enter beginning and ending dates of the period included on this bill (MMDDYYYY).
7	Untitled		

**CLAIMS SUBMISSION**

Box #	Field name	Required	Instructions
8a	Patient ID #	YES	Enter patient's thirteen (13) digit ID number.
8b	Patient name	YES	Enter patient's last name, first name, middle initial as name appears on ID card.
9	Patient address	YES	Enter patient's mailing address.
10	Birth date	YES	Enter patient's date of birth (MMDDYYYY).
11	Sex	YES	Enter patient's sex M = Male F = Female
12	Admission date	YES	Enter date of admission (MMDDYYYY).
13	Admission hour	YES	Enter time of admission or visit.
14	Type of admission	YES	For inpatient admission, enter code indicating the priority of this admission. 1 – Emergency 2 – Urgent 3 – Elective 9 – Information not available
15	Source of admission	YES	Enter code indicating the source of this admission/visit. 1 – Physician referral 2 – Clinic referral 3 – HMO referral 4 – Transfer from a hospital 5 – Transfer from a SNF 6 – Transfer from another facility

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
			7 – Emergency room 8 – Court/law enforcement 9 – Information not available A – Transfer from a rural primary care hospital
16	Discharge hour	YES	Enter time patient was discharged.
17	Patient status through	YES	Enter code to indicate patient status as of date on this billing.
19-28	Condition codes	YES	Enter codes to identify conditions related to this bill that may affect processing.
29	Accident state	NO	
31-36	Occurrence codes and dates	YES	Enter code(s) and associated date(s) defining specific event(s) relating to this bill that may affect processing.
37	Untitled	NO	Not applicable to FCHP.
38	Responsible party name/address	NO	
39-41	Value codes and amounts	NO	Not applicable to FCHP.
42	Revenue code	YES	Enter billing revenue code. (Medicare revenue codes)
43	Revenue description	YES	Enter the Revenue Code description. Use CPT-4 HCPCS definitions whenever possible.

**CLAIMS SUBMISSION**

Box #	Field name	Required	Instructions
44	HCPCS/rates	YES	Enter the CMS procedure code or CPT-4 code.
45	Service date	YES	Enter the date service was provided.(MMDDYYYY)
46	Service units	YES	Enter the units of service rendered per claim line. Physical therapy and home health services—bill units as indicated in contract.
47	Total charges	YES	Enter the charges for each claim line.
48	Non-covered charges	YES	Reflect non-covered charges related to a specific revenue code or line item.
49	Untitled	NO	Not applicable to FCHP.
50	Payer	YES	Enter all health insurance carriers. Attach an EOB from other carrier, if applicable. Use this box to indicate if result of an accident (MVA, Workers Compensation, subrogation).
51	Provider number	YES	Enter your FCHP provider ID number.
52	Release of information	Optional	A "Y" code indicates the provider has on file a signed statement permitting the provider to release data in order to adjudicate the claim. An "N" code indicates no release on file.
53	Assignments of benefits	Optional	Enter Y or N.
54	Prior payments	YES	Enter all prior payments. Attach an EOB from other carrier, if applicable.

**CLAIMS SUBMISSION**

Box #	Field name	Required	Instructions
55	Estimated amount due	NO	Not applicable to FCHP.
56	NPI	YES (eff 5/23/07)	
57	Other provider ID	NO	.
58	Insured's name	YES	Enter the name of the individual in whose name the insurance is carried.
59	Patient's relationship to insured	YES	Enter the code, which indicates the patient's relationship to the insured. 01 – Subscriber 02 – Spouse 03 through 99 – Dependent child
60	Certificate/ Social Security #/ health insurance claim/identification #	YES	Enter the FCHP ID # as indicated on the member's ID card.
61	Group name	YES	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	YES	Enter the number assigned by FCHP to identify the group under which the individual is covered.
63	Treatment auth. codes	YES	Enter the authorization/referral number assigned by FCHP.

**CLAIMS SUBMISSION**

Box #	Field name	Required	Instructions
64	Document control number		
65	Employer name	YES	Enter the name of the employer who provides health care coverage for the individual identified in box 58.
66	Diagnosis version qualifier	YES	
67	Principal diagnosis code	YES	Enter the ICD-9-CM diagnosis code indicating the principal diagnosis; describing the condition established to be chiefly responsible for the admission or outpatient care. The code reported must be the full ICD-9-CM diagnosis code including all digits applicable (i.e., fourth or fifth digit).
68	Untitled	YES	
69	Admitting diagnosis	YES	Enter the ICD-9-CM diagnosis code provided at the time of the admission as stated by the physician.

**CLAIMS SUBMISSION**

Box #	Field name	Required	Instructions
70	Patient reason for visit Code		
71	PPS Code		
72	External cause of injury (E-code)	YES	Enter the ICD-9-CM diagnosis code for external cause of an injury, poisoning or adverse effect.
73	Untitled		
74	Principal procedure code	YES	Enter the ICD-9-CM procedure code to indicate the principal procedure performed for this billed service. Enter the date the procedure was performed. (MMDDYYYY)
74 (a-b)	Other procedure	YES	Enter the ICD-9-CM procedure code identifying all significant procedures, other than the principal procedure. Enter the dates the procedures were performed. (MMDDYYYY)
75	Untitled		
76	Attending physician ID NPI number and name	YES	Enter the last name, first name and middle initial.
77	Operating physician ID NPI number and name		
78	Other physician ID NPI number and name	YES	Enter last name, first name and middle initial.

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**CLAIMS SUBMISSION**

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Box #	Field name	Required	Instructions
79	Other physician ID NPI number and name		
80	Remarks	NO	Enter remarks needed to provide information that is not reported elsewhere on the claim but which may be necessary to ensure payment.
81 (a-d)	Code-Code		

Source: Health Care Finance Administration, HCFA 1450

# CLAIMS SUBMISSION

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UB-04 CMS-1450

APPROVED CMS NO. 0938-0997



THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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## CLAIMS SUBMISSION

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UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

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SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

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**CLAIMS SUBMISSION**

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F. Billing and payment guidelines for facility claims

Topics	Billing and payment guidelines
Behavioral Health	<p>All behavioral health outpatient admissions should be submitted to:</p> <p style="text-align: center;">Beacon Health Strategies 500 Unicorn Park Drive Woburn, MA 01801</p> <p>Behavioral health claims for Non-MA Fallon Preferred Care members should be mailed to: Fallon Community Health Plan Claims Department P.O. Box 15207 Worcester, MA 01615-0207</p>
Emergency Department Services	<ul style="list-style-type: none"> <li>• Charges for emergency department resulting in an observation stay are considered part of the observation charge and will be paid as observation room services.</li> <li>• Charges for emergency department services resulting in an outpatient surgery performed outside of the emergency room will be reimbursed as a same day surgery.</li> <li>• If the emergency department results in an admission, the emergency department charges will be considered under the inpatient stay. The emergency department technical charge is considered part of the inpatient stay and will be paid as inpatient services.</li> </ul>
Laboratory	<ul style="list-style-type: none"> <li>• Only technical services should be billed on UB-04 claim forms.</li> <li>• Revenue, CPT and HCPCS codes should be used.</li> <li>• Ordering physician should be listed in Box 78 on the UB-04 claim form.</li> </ul>
Medical Supplies (Revenue codes 0270 and 0279)	<p>Must include itemization if billed amount exceeds \$200 (other than services billed as part of a same-day surgery, emergency department, observation or inpatient claim.)</p>

Outpatient

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines
<i>Outpatient</i>	<p>Observation</p> <ul style="list-style-type: none"> <li>• Bill observation (room charges) services under revenue code 0762 for both outpatient and inpatient claims.</li> <li>• Bill observation (room charges revenue code 0762) services on one claim line indicating the total number of hours in the service unit field.</li> <li>• Bill all services administered during the observation service on the same claim.</li> <li>• Observation services not related to a subsequent admission, the hospital must bill as an outpatient service and FCHP will pay either the lower of charges or the contracted observation services rate if the FCHP Case Manager has authorized the observation service.</li> <li>• For observation services provided on the day prior to or the day of an inpatient admission, observation services will fall under the all inclusive inpatient per diem or case rate for that inpatient stay. Observation services will not be reimbursed separately.</li> <li>• Observation services billed in conjunction with a surgical procedure that is categorized as same day surgery will be processed as same day surgery. Observation services will not be reimbursed separately.</li> </ul>
	<p>Outpatient Clinic/ Facility Charges</p> <ul style="list-style-type: none"> <li>• FCHP does not reimburse for facility charges (0510) associated with Evaluation and Management services, unless contractually obligated.</li> <li>• The hospital should bill for services of salaried physicians on a CMS-1500 claim form. (The professional reimbursement is a global payment that includes an allocation for the administrative cost of using the facility.)</li> </ul>

**CLAIMS SUBMISSION**

Topics	Billing and payment guidelines
Pathology	<ul style="list-style-type: none"> <li>• Only technical services should be billed on UB-04 claim forms.</li> <li>• Revenue, CPT and HCPCS codes should be used.</li> <li>• Ordering physician should be listed in Box 78 on the UB-04 claim form.</li> </ul>
Pharmacy Services (Revenue codes 0250 and 0636)	<ul style="list-style-type: none"> <li>• Requires itemization (name and quantity of drugs dispensed) if the billed amount exceeds \$200 (other than services billed as part of a same-day surgery, emergency department, observation or inpatient claim).</li> <li>• Claims submitted with 0636 must include the HCPCS code and an itemized invoice.</li> </ul>
Physical Therapy	<ul style="list-style-type: none"> <li>• Revenue, CPT and HCPCS codes should be used.</li> <li>• Report each date of service individually.</li> </ul>
Radiology	<ul style="list-style-type: none"> <li>• Only technical services should be billed on UB-04 claim forms.</li> <li>• Revenue, CPT and HCPCS codes should be used.</li> <li>• Ordering physician should be listed in Box 78 on UB-04 claim form.</li> <li>• When reporting (bilateral) radiological services you should use the – RT and –LT modifiers. Radiological services should be billed on two claim lines with the –RT and –LT modifier and one unit on each line. Do not use the –RT and –LT modifier to report services already identified as bilateral by definition.</li> </ul>

Outpatient

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**CLAIMS SUBMISSION**

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Topics	Billing and payment guidelines
<i>Outpatient</i>	<p>Same-Day Surgery</p> <ul style="list-style-type: none"> <li>• The CPT code for the surgical services must appear on each line next to the operating room revenue code.</li> <li>• Claim lines with \$0.00 amount billed will not be reimbursed.</li> <li>• When multiple surgical procedures are performed at the same session, the primary procedure will be reimbursed at 100% of the billing facility's contracted rate. Reimbursement for second through fifth surgical procedures will be at 50% of the billing facility's contracted rate in accordance with Medicare guidelines or as otherwise stated in facility's contract. The primary procedure is determined by the highest allowable rate. There is no additional reimbursement beyond the fifth procedure.</li> <li>• Operative notes may be requested for claims with billed amounts of \$5000 or greater.</li> </ul>
	<p>VNA</p> <ul style="list-style-type: none"> <li>• Revenue and CPT/HCPCS codes should be used for all services.</li> <li>• Each date of service should be reported individually.</li> <li>• For home health aide services, refer to your contract for the requirements on the number of units to bill. In some contracts, the units equal one per hour. Other contracts specify one unit equals fifteen minutes.</li> </ul>

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**CLAIMS SUBMISSION**

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Topics	Billing and payment guidelines
<i>Inpatient</i>	<p>Behavioral Health</p> <p>Behavioral health claims should be submitted to:</p> <p style="padding-left: 40px;">Beacon Health Strategies 500 Unicorn Park Drive Woburn, MA 01801</p> <p>Behavioral health claims for Fallon Preferred Care members and Senior Preferred Care members should be mailed to:</p> <p style="padding-left: 40px;">Fallon Community Health Plan Claims Department P.O. Box 15207 Worcester, MA 01615-0207</p>
<i>Inpatient</i>	<p>Maternity</p> <ul style="list-style-type: none"> <li>• Mother and newborn charges must be submitted together when both parties are discharged on the same day.</li> <li>• When newborn is not discharged at the same time as the mother, separate authorization is required beginning with the mother's discharge date.</li> <li>• A separate claim for the newborn must be submitted with dates of service occurring after the mother's discharge date.</li> </ul>
<i>Inpatient</i>	<p>Transfers</p> <p>Intra-hospital transfers from a medical/surgical unit to either a psychological or rehabilitation unit, or vice versa, must be billed separately according to the unit within which the care is provided.</p>

## **5. Coordination of benefits**

When more than one insurance plan covers a service, the plans work together to pay for the service. This is called coordination of benefits. This occurs when a person has coverage from more than one company, or when Medicare, workers' compensation or an auto accident claim is involved. In order for services to be considered for payment as a secondary insurer, Fallon Community Health Plan's policy and procedures for referrals and authorizations must be followed.

### **Why do the insurance plans coordinate benefits?**

Payments are coordinated to prevent total payments from exceeding the total charges for the patient's health services.

### **How do I know where to send the claims?**

All insurance companies use the same rules to determine the primary and secondary carriers. These rules are explained below. If another company is the primary carrier, you should first send the bills to that company. After you receive the other insurer's Explanation of Benefits, submit a copy of that document to us with the CMS 1500 claim form or UB-04 claim form. Complete information on the other insurer must be shown in Boxes 11 and 24j of the CMS 1500 claim form or Box 50 on the UB-04 claim form.

### **Are there limits on when a claim can be filed with FCHP?**

Claims must be filed within 120 days from the date on the other insurance carrier's Explanation of Benefits. If your contract with FCHP specifies a different time limit, that limit may apply. Remember to include the Explanation of Benefits from the other carrier with your claim forms.

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**COORDINATION OF BENEFITS**

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**How is primary coverage determined?**

Situation	Coverage
More than one possible carrier	
Spouse	If the subscriber's spouse has other health insurance, that is the spouse's primary plan.
Dependent children	Claims are processed using the birthday rule. The primary carrier is the insurance of the parent whose birth date occurs first in the calendar year. Example: mother's birthday is August 20; father's birthday is April 2. The primary carrier for the dependent child is the father's plan. When both parents have the same birth date, the primary carrier for the dependent child is the plan that has been in effect the longest.
Special situations for dependent children	
Joint custody	If neither parent is specified as responsible for health insurance, the birthday rule applies.
Court decree	If the court decree specifies that one parent is responsible for health coverage, that parent's plan is primary.
Single custody	The following order applies: 1. Parent with custody 2. Spouse of parent with custody.

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**COORDINATION OF BENEFITS**

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<b>Medicare</b>	
<p>Rules are determined by Medicare Secondary Payer (MSP) laws. These laws apply to age 65 or older active employees and their spouses who are enrolled in a group health plan of an employer with at least 20 employees. In these cases, the employee would have coverage through the group and also through Medicare.</p>	
Subscriber is age 65 or older and is still working	FCHP is primary Medicare is secondary
Subscriber is age 65 or older and is retired	Medicare is primary FCHP is secondary
Actively employed subscriber's spouse is 65 or older	FCHP is primary Medicare is secondary
Retired subscriber's spouse is 65 or older	Medicare is primary FCHP is secondary
Medicare entitlement due to end stage renal disease or disability	Special rules apply. Please call 866-ASK-FCHP (866-275-3247) with any questions.

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**COORDINATION OF BENEFITS**

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<b>How are motor vehicle accident (MVA) claims handled?</b>	
Determining primary coverage	The automobile insurance company is primary for the first \$2,000 in medical expenses under the Personal Injury Protections (PIP). If the member is covered under the Fallon Senior Plan™ or MassHealth, the automobile insurance is primary for \$8,000 under the PIP. FCHP will adjust claims accordingly if it is determined that services are a result of an MVA after the claims have been processed.
Submitting claims	<p>Use the CMS 1500 claim form or UB-04 claim form. Record name of auto insurance carrier or other responsible party in Box 9 of the CMS 1500 claim form or Box 50 of the UB-04 claim form. Indicate that the services are as a result of an MVA and include the following:</p> <ul style="list-style-type: none"> <li>• Auto claim number</li> <li>• Date of accident</li> <li>• PIP insurance carrier</li> <li>• Address of PIP carrier</li> <li>• Notice from the PIP carrier stating that benefits have been exhausted</li> <li>• Name of patient's attorney</li> </ul> <p>FCHP will process claims providing that the member completes an assignment of insurance payment form. If the member does not complete the form, claims will be held until the coordination of benefits with the automobile insurance or other responsible party is settled.</p>
Filing limits	An MVA claim must be submitted to Fallon Community Health Plan within 120 days or your contracted time frame from the date of the other insurance Explanation of Benefit. Please attach the Explanation of Benefit or PIP exhaustion letter from the other insurance carrier.

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**COORDINATION OF BENEFITS**

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**How are motor vehicle accident (MVA) claims handled?**

Referrals and authorization guidelines	In order for services to be considered for payment, Fallon Community Health Plan's policies and procedures for referrals and authorizations must be followed. See section titled Referral and Preauthorization Guidelines.
Claims adjustments	Fallon Community Health Plan will adjust claims accordingly if it is determined that services are result of an MVA after the claims have been processed.
Balance billing	Balance billing FCHP members is not allowed.

**How are workers' compensation claims handled?**

Fallon Community Health Plan does not reimburse for services related to a work illness or injury.	
Submitting claims	The claim should first be submitted to the workers' compensation carrier. If the claim is denied, submit proof of the workers' compensation denial to FCHP. Upon receipt, we will review the claims for payment. After claims have been processed, FCHP will adjust claims accordingly if it is determined that services are the result of a work related injury.
Claims filing limits	Claims must be submitted to Fallon Community Health Plan within 120 days or your contracted time frame from the date of the denial from the workers' compensation carrier.
Referrals and authorization guidelines	In order for services to be considered for payment, Fallon Community Health Plan's policies and procedures for referrals and authorizations must be followed. See section titled Managing Care.

**What is subrogation?**

Subrogation applies when a payment for a member's illness or injury may be the responsibility of a third party. Examples of subrogation cases may be a result of an injury in a public place, slips and falls, or a dog bite.

Submitting claims

Please provide:

- Date of accident
- File number
- Name of patient's attorney

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## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY

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### 6. Claim status checks

Contact the claims customer service team to check on the status of claims you have submitted. They are available to assist you Monday through Friday from 8 a.m. to 12 noon and from 1 p.m. to 5 p.m.

The Claims Department can be reached at:

Telephone number: 1-866-ASK-FCHP (1-866-275-3247)  
Fax number: 508-797-4292  
Mailing address: Fallon Community Health Plan  
Claims Department – Adjustment Unit  
P. O. Box 15121  
Worcester, MA 01615-0121

Please note the following:

- Status requests can be mailed, faxed or telephoned.
- Inquiries are limited to three per telephone call. High volume requests should be mailed or faxed.
- Status checks should be made 45 days after submission of a claim to FCHP. This allows FCHP time to process your claim and you time to resubmit prior to the filing limit.
- Please clearly mark the claim "STATUS INQUIRY" in order to avoid duplicate entry.
- Please submit claims status requests separately from new dates of service. Please do not submit status requests electronically.

### 7. Understanding your remittance advice summary

For specific details on electronic Remittance Advice Summaries, please refer to our companion guide: Health Care Payment/Advice ANSI X12 835 (Version 004010X091A1) Implementation Guide at <http://www.fchp.org/providers/provider-tools/edi-companion-guides.aspx>.

#### A. Remittance Advice Summary — Field Definition

A Remittance Advice Summary (RAS) is a printed explanation of the adjudication of a claim. Here is a description of each field on the RAS. See the reference section for a detailed description of FCHP's adjudication codes.

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**UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY**

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	FIELD	DEFINITION
1	Provider	The name of the provider rendering services.
2	Member name	The name of the member to whom the service was provided.
3	Contract #	The member's ID number
4	Referral #	The number of the referral to which the claim is linked, if applicable.
5	Claim #	The number assigned by FCHP to the claim.
6	Post date	The date on which the claim was posted to the system.
7	Account number	The account number submitted by the provider.
8	Statis flag (S/F)	Statis flag: Y or N appears in this field, indicating if the claim is approved as statistical (reporting purposes) or non-statistical (fee for service). Statistical (Y) or non-statistical (N).
9	Procedure	The procedure code(s) and description(s) submitted on the claim.
10	Modifier (MOD)	The primary modifier code submitted on the claim.
11	Service dates	The service from and to dates, on the claim line.
12	Billed	The total amount billed on the claim line.
13	Rejected	The total amount rejected on the claim line. Refer to legend for detailed explanation.
14	Deductible (Deduct)	The amount the member must pay towards his or her deductible and or coinsurance.

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**UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY**

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	FIELD	DEFINITION
15	Copay amount	The amount the member must pay as a copayment and/or coinsurance.
16	Approved	The total approved amount on the claim line.
17	Withheld	The total amount withheld based on the contractual agreement with the vendor.
18	Refund	The total amount of money received back from the provider and applied to the claim.
19	Interest	The total amount of money paid to the provider due to late payment by FCHP.
20	Net	The net amount, including all non-statistical approved dollars on the claim line.
21	Claim totals	Subtotal, by claim.
22	Notes	An information field is provided at the end of a claim. The purpose of this field is to provide helpful information for future billing, such as "Please update member's ID #".
23	Provider summary	Totals split out by statistical claim totals, non statistical claim totals and negative balance amounts.
24	Provider net amount	The total amount of the check issues for this Remittance Advice Summary.
25	Legend	The legend indicates the claim line rejection disposition codes and their descriptions. Further explanations are located in Section 6B. <a href="#">Explanation of disposition codes</a> .

A message section is provided on the last page of your RAS to notify you of important information or helpful facts.

## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY



pg # of #

Master Vendor Number:	99999
Entity Number:	001
Date:	12/12/2004
Check Number:	1234567
Check Amount:	\$400.00

2	3	4	1	5	6	7	8					
Name	Contract #	Referral #	Claim Vendor	Claim #	Post Date	Account Number	Status Flag					
MEMBER NAME	XXXXXXXXXX*01	XXXXXXXXXX	COMMUNITY HOSPITAL	XXXXXXXXXXXXXX	04/14/05	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	N					
Procedure	MOD	Service Dates	S/F	Billed	Rejected	Deduct	Copay	Approved	Withheld	Refund	Interest	Net
49080 PERITONEOCENTESIS ABD PARA:		04/06/05 - 04/06/05	N	1,400.00	1,000.00 <sup>451</sup>	0.00	0.00	400.00	0.00		0.00	400.00
9	10	11	8	12	13	14	15	16	17	18	19	20
Claim Totals	21			1,400.00	1,000.00	0.00	0.00	400.00	0.00	0.00	0.00	400.00

Note: PLEASE UPDATE MEMBER'S ID # 22

23	24
Vendor Summary	Vendor Net Amount
Vendor Non-Statistical Claims Totals	1,400.00 1,000.00 0.00 0.00 400.00 0.00 0.00 0.00 400.00
Vendor Claims Totals	1,400.00 1,000.00 0.00 0.00 400.00 0.00 0.00 0.00 400.00
Vendor Net Amount	\$400.00

FCHP has a 120 day adjustment and appeal period from the date of your Remittance Advice Summary. Any requests for an adjustment or appeal received after the 120 days will not be accepted. Please refer to the FCHP Provider Manual at [www.fchp.org](http://www.fchp.org) for additional information.

INFORMATIONAL MESSAGE WILL APPEAR HERE.  
IT MAY BE ONE OR TWO LINES LONG.

25

Legend	
Number	Description
451	REJECT MEMBER PENALTY NO PRECE

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## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY

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### B. Denial Reasons

Denial reasons are assigned to each claim line. They provide brief explanations of why the claim line was rejected. Below is the list of denial reasons:

ID	Type	DENIAL REASON
DF001	REMIT	Denied-above invoice cost
DF002	EOB	Denied-above authorization limit
DF002	REMIT	Denied-above authorization limit
DF003	REMIT	Denied-admission source required
DF004	REMIT	Denied-admit type required
DF005	REMIT	Denied-age invalid per medical policy
DF006	REMIT	Denied-age/procedure conflict
DF007	EOB	Denied-appeals review
DF007	REMIT	Denied-appeals review
DF008	REMIT	Denied-assistant surgeon not necessary
DF009	REMIT	Denied-authorization line not approved
DF010	REMIT	Denied-authorized services do not match billed
DF011	EOB	Denied-benefit has age restriction
DF011	REMIT	Denied-benefit has age restriction
DF012	EOB	Denied-benefits no longer administered by FCHP
DF012	REMIT	Denied-benefits no longer administered by FCHP
DF013	REMIT	Denied-bill as observation
DF014	REMIT	Denied-claim document or information not received
DF015	REMIT	Denied-clinical trial
DF016	REMIT	Denied-co surgeon not allowed
DF017	REMIT	Denied-detail supply code needed
DF018	REMIT	Denied-diagnoses invalid per medical policy
DF019	REMIT	Denied-discharge status required
DF020	REMIT	Denied-duplicate claim line
DF021	REMIT	Denied-exceeds review time limit
DF022	REMIT	Denied-gender invalid per medical policy
DF023	REMIT	Denied-gender/procedure conflict
DF024	REMIT	Denied-HDI repricing applied in error
DF025	REMIT	Denied-hospice primary
DF026	REMIT	Denied-ICD9 diagnosis code invalid for dos
DF027	REMIT	Denied-ICD9 diagnosis required
DF028	REMIT	Denied-ICD9 procedure code invalid for dos
DF029	REMIT	Denied-ICD9/CPT code mismatch
DF030	REMIT	Denied-incident to other procedure
DF031	REMIT	Denied-included in admission
DF032	REMIT	Denied-included in global fee
DF033	REMIT	Denied-incorrect bill
DF034	REMIT	Denied-incorrect date of service
DF035	REMIT	Denied-incorrect medical notes

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## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY

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DF036	REMIT	Denied-incorrect number of units billed
DF037	REMIT	Denied-incorrect place of service
DF038	REMIT	Denied-incorrect provider
DF039	REMIT	Denied-invalid REV code
DF040	REMIT	Denied-invalid condition code on dos
DF041	REMIT	Denied-invalid CPT/HCPCS for dos
DF042	EOB	Denied-invalid diagnosis code for benefit
DF042	REMIT	Denied-invalid diagnosis code for benefit
DF043	REMIT	Denied-invalid mod/CPT combo
DF044	REMIT	Denied-invalid modifier for dos
DF045	REMIT	Denied-invalid occurrence code on dos
DF046	REMIT	Denied-invalid occurrence span code on dos
DF047	REMIT	Denied-invalid or missing admission date
DF048	REMIT	Denied-invalid REV/CPT code combo
DF049	REMIT	Denied-invalid value code on dos
DF050	REMIT	Denied-invoice required
DF051	REMIT	Denied-itemization required
DF052	REMIT	Denied-late charges/corrections
DF053	EOB	Denied-max benefit limit exceeded
DF053	REMIT	Denied-max benefit limit exceeded
DF054	REMIT	Denied-Medicaid CRNA not allowed
DF055	REMIT	Denied-medical criteria not met
DF056	REMIT	Denied-medical notes required
DF057	REMIT	Denied-medical visit not paid separately
DF058	EOB	Denied-member not enrolled on dos
DF058	REMIT	Denied-member not enrolled on dos
DF059	REMIT	Denied-modifier is invalid per medical policy
DF060	REMIT	Denied-modifier missing
DF061	REMIT	Denied-modifier on claim does not match contract term
DF062	REMIT	Denied-motor vehicle accident
DF063	REMIT	Denied-mutually exclusive service
DF064	EOB	Denied-no authorization
DF064	REMIT	Denied-no authorization
DF065	REMIT	Denied-no available bed days on auth
DF066	REMIT	Denied-no response
DF067	REMIT	Denied-no supporting documentation
DF068	EOB	Denied-not a covered benefit
DF068	REMIT	Denied-not a covered benefit
DF069	REMIT	Denied-not paid separately
DF070	REMIT	Denied-NPI invalid format
DF071	REMIT	Denied-NPI missing
DF072	REMIT	Denied-NPI not matched
DF073	REMIT	Denied-OP notes required
DF074	REMIT	Denied-original bill in review

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## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY

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DF075	REMIT	Denied-other agency may be responsible for payment
DF076	REMIT	Denied-other insurance primary
DF077	REMIT	Denied-over submit date
DF078	REMIT	Denied-paid by other insurance
DF079	REMIT	Denied-PHCS repricing applied in error
DF080	REMIT	Denied-physician specialty is invalid for medical policy
DF081	REMIT	Denied-place of service invalid per medical policy
DF082	REMIT	Denied-prior authorization not approved
DF083	REMIT	Denied-provider specialty not appropriate for service
DF084	REMIT	Denied-provider type is invalid per medical policy
DF085	REMIT	Denied-provider type not appropriate for service
DF086	REMIT	Denied-readmit related DRG
DF087	REMIT	Denied-readmit same DRG
DF088	REMIT	Denied-rebill initiating hospital for transport
DF089	REMIT	Denied-rebill with anesthesia CPT code
DF090	REMIT	Denied-rebill with correct tax id#
DF091	REMIT	Denied-rebill with referring physician
DF092	REMIT	Denied-rebill with rendering physician
DF093	REMIT	Denied-rebundled
DF094	REMIT	Denied-referring provider not PCP
DF095	REMIT	Denied-retro review request
DF096	REMIT	Denied-send ambulance trip sheet
DF097	REMIT	Denied-send ER record
DF098	REMIT	Denied-services not on provider contract
DF099	REMIT	Denied-submit on 1500 form w rendering physician
DF100	REMIT	Denied-submit to ASHN
DF101	REMIT	Denied-submit to Beacon Health Strategies
DF102	REMIT	Denied-submit to Dental Benefit Providers (DBP)
DF103	REMIT	Denied-submit to Lifetrac Network
DF104	REMIT	Denied-submit to skilled nursing facility
DF105	REMIT	Denied-submit to United Behavioral Health
DF106	REMIT	Denied-team surgeon not allowed
DF107	REMIT	Denied-too many units billed for service
DF108	REMIT	Denied-units exceeded per medical policy
DF109	EOB	Denied-workers compensation
DF109	REMIT	Denied-workers compensation
DF110	REMIT	Denied-excluded service provider liable
DF111	REMIT	Denied-E&M code not valid for established patient
DF112	EOB	Denied-member penalty no precertification
DF112	REMIT	Denied-member penalty no precertification
DF113	REMIT	Denied-anesthesia time required
DF114	REMIT	Denied-incorrect procedure code after OP-Note Review

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## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY

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DF115	REMIT	Denied-paid in error
DF116	REMIT	Denied-invalid from or thru date of service
DF117	REMIT	Denied-incorrect bill type
DF118	REMIT	Part D-Submitted to Pharmacare
DF119	REMIT	Denied-maximum approved units of service exhausted
DF120	REMIT	Denied-not a preferred provider
DF121	REMIT	Denied- Incorrect billing according to Medicare guidelines
DF122	REMIT	Denied- Incorrect billing according to Medicare OPPS guidelines
DF123	REMIT	Denied- missing end date on claim
DF124	REMIT	Denied-claim submitted to beacon for review
DF125	REMIT	Denied-incorrect procedure code
DF126	REMIT	Denied-referring physician not within member's HCO
DF127	REMIT	Denied-referring physician NPI is invalid
DF128	REMIT	Denied-state supplied vaccine no reimbursement
DF129	REMIT	Denied - incorrect modifier
DF130	REMIT	Denied - incomplete notes
DF131	REMIT	Denied - submit with code
DF132	REMIT	Denied-sds service requires cpt/hcpc code
DF133	REMIT	Denied-claim total billed does not equal claim lines
DF134	REMIT	Denied-place of service incorrect for billed service
RF001	REMIT	Contractual adjustment
RF002	REMIT	Medicaid adjustment
RF003	REMIT	Medicare adjustment
RF004	REMIT	COB applied

### Sample Pended Claims Report

The pended claims report is to notify you that we have received the claims. The claims are being reviewed and no further action is required at this time. When the review is completed the final disposition will appear on your Remittance Advice Summary.

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## UNDERSTANDING YOUR REMITTANCE ADVICE SUMMARY

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pg 1 of 1

Master Vendor Number:	###
Date:	12/12/2004
PENDED CLAIMS REPORT	

This report is to notify you that we have received the claims listed below.  
The claims are currently being reviewed and no further action is required from your office at this time.  
Once the review is completed, the final disposition will appear on your Remittance Advice Summary.

Payee: GENERAL HOSPITAL  
STREET ADDRESS

Member Name	Claim #	DOS	Vendor Acct #	Billed Amount	Rendering Physician (if other than Payee)
MEMBER NAME	999999999999	04/05/2005		1500.00	
MEMBER NAME	999999999999	04/05/2005		500.00	

If you have not received a determination within 45 days, you may call Claims Customer Service at 1-866-ASK-FCHP (Press 1)  
and a FCHP representative will be happy to assist you.

## 8. Overpayments on FCHP's part

### What is an overpayment?

Overpayment occurs when we send you more money than we should have in payment of a claim.

### What should I do if this happens?

You should either return our check or issue a refund check to FCHP. Your refund to us will be credited to your account. Please follow the procedures below:

If you are returning our check, please include the following:

- The Remittance Advice Summary that was received with the check
- The reason you are returning the check
- Name and phone number of the contact person at your office

If you are sending us a refund check please include the following:

- Member name
- Membership number
- Member date of birth
- Date of service or the Remittance Advice Summary that was received with the check. Highlight the pertinent information.
- Reason for the refund
- Name and phone number of the contact person at your office

Checks should be mailed to:

Fallon Community Health Plan  
Finance Department  
10 Chestnut Street  
Worcester, MA 01615-0121

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## NEGATIVE BALANCES

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### 9. Negative balances

Fallon Community Health Plan periodically audits claim payment activity to identify payments made to providers in error. Those payments made in error will be adjusted on the provider's account showing the amount overpaid as a negative amount originally paid in error.

In some instances a negative balance is generated when the total amount of adjusted claim dollars is greater than a provider's positive claim payment activity. If a provider is in a negative balance status with FCHP, the last page of your Remittance Advice Summary (RAS) will show the total amount due to FCHP. You will only receive the detailed patient claim information on the original negative balance RAS. Please be sure to keep this negative balance RAS as this will be needed to post your accounts.

If you anticipate the amount due FCHP will be cleared by future claim submissions, you may choose not to remit a refund to FCHP. However, if you wish to remit payment for the amount due, you may do so by making a check payable to FCHP and sending it to the address below. Please include a copy of the last page of your RAS.

Fallon Community Health Plan  
Attn: Adjustment Unit  
10 Chestnut St.  
Worcester, MA 01608

The Claims Department will send a report and a letter of explanation to the provider at intervals of 30/60/90 days from when the negative balance was created. FCHP will not issue any future payments until the negative balance is cleared.

When sending your refund check, please enclose a copy of the letter and report sent to you

## ADJUSTMENTS AND PROVIDER APPEALS



### NEGATIVE BALANCE NOTIFICATION

RAS Page

Pay-To Provider Number:	
Pay-To Provider Name:	
Entity Number:	
Date:	
Check Number:	N/A
Check Amount:	N/A

Name	Contract #	Referral #	Provider	Claim #	Post Date	Account Number						
Procedure 85730	MOD	Service Dates	S/F N	Billed 61.00	Rejected 9.15 <sup>RF001</sup>	Deduct 0.00	Copay 0.00	Approved 51.85	Withheld 0.00	Refund 0.00	Interest 0.00	Adj Net Amt 51.85
<b>Claim Totals</b>				<b>197.00</b>	<b>29.55</b>	<b>0.00</b>	<b>0.00</b>	<b>167.45</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>167.45</b>
<b>Adjusted Claim Totals</b>				<b>167.45</b>								
<b>Provider Summary</b>				<b>Billed</b>	<b>Rejected</b>	<b>Deduct</b>	<b>Copay</b>	<b>Approved</b>	<b>Withheld</b>	<b>Refund</b>	<b>Interest</b>	<b>Adj Net Amt</b>
Provider Non-Statistical Claims Totals				235,313.73	208,339.85	1,046.35	950.00	24,977.53	0.00	0.00	326.36	25,303.89
Negative Balance Previously Applied				-38,733.94								
<b>Provider Claims Totals</b>				<b>-13,430.05</b>								
<b>Provider Net Amount</b>				<b>\$-13,430.05</b>								

FCHP has a 120 day adjustment and appeal period from the date of your Remittance Advice Summary. Any requests for an adjustment or appeal received after the 120 days will not be accepted. Please refer to the FCHP Provider Manual at [www.fchp.org](http://www.fchp.org) for additional information.

Legend	Number	Description
	205	Benefit requires authorization
	611	Prior authorization has no available units
	DF013	Denied-bill as observation
	DF033	Denied-incorrect bill
	DF058	Denied-member not enrolled on dos
	IF032	Rebill with correct admit date
	MF01	Service not separately reimbursed
	RF001	Contract Adjustment
	RF004	COB Applied



## 10. Adjustments and Appeals

If you do not agree with a claim determination made by FCHP, you have the right to request a claim review.

### Review Types

A Request for Claim Review may be related to one of the following:

- **Contract term(s):** The provider believes the previously processed claim was not paid in accordance with negotiated terms.
- **Coordination of Benefits:** The requested review is for a claim that could not fully be processed until information from another insurer has been received.
- **Corrected Claim:** The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made.
- **Duplicate Claim:** The original reason for denial was due to a duplicate claim submission.
- **Filing Limit:** The claim whose original reason for denial was untimely filing.
- **Payer Policy, Clinical:** The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
- **Payer Policy, Payment:** The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
- **Pre-Certification/Notification or Prior-Authorization or Reduced Payment:** The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
- **Referral Denial:** The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
- **Request for additional information:** The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC Codes, Home Infusion Therapy).
- **Retraction of Payment:** The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).

### Submission Requirements

All claim review requests must be received in writing within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS) in order to be considered for review. All claims must be processed by FCHP prior to the submission of a request for claim review. A separate provider request for claim review form must be supplied for each appeal and all pertinent supporting documentation must be attached. Please refer to the Request for Claim Review Reference Guide for examples of review types and required documentation for each review request.

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## ADJUSTMENTS AND PROVIDER APPEALS

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Please mail or fax your appeal request to:

Fallon Community Health Plan  
Attn: Request for Claims Review/Provider Appeals  
P. O. Box 15121  
Worcester, MA 01615-0121  
Fax: 508-368-9890

### Filing Limit Appeals

All claim review requests must be received in writing within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS) in order to be considered for review. All claims must be processed by FCHP prior to the submission of a claim review request. Any request received after this timeframe will not be considered for review.

### Filing Limit Appeal Requirements

- Submit a separate Request for Claims Review Form for each appeal.
- Copy of FCHP Claims Metrics Report or Copy of original FCHP RAS
- CMS-1500/ADA/UB claim form
- Supporting Documentation

### Supporting Documentation

#### Paper claims

If you are requesting a filing limit claim review of a claim that was submitted on paper, the following are acceptable proofs of timely submission.

- Copy of patient account ledger which indicates the patient's name, date of service and the date the claim was submitted to Fallon Community Health Plan.
- If the member or another insurer had been previously billed, include proof that the member or another carrier had been billed (ledger).
- Clinical notes, medical records, discharge summary (should the filing limit denial pertain to services such as an inpatient admission or outpatient observation)
- RAS from other insurer

#### EDI Claims

If you are requesting a filing limit claim review of an EDI claim, submitted either through a clearinghouse, or directly to Fallon Community Health Plan, only the following are acceptable proofs of timely submission.

- 997 Report

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## ADJUSTMENTS AND PROVIDER APPEALS

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- EDI Clearinghouse report indicating that the claim was accepted by FCHP within the filing limit

### Additional information regarding EDI Claims

Fallon Community Health Plan does not routinely waive the filing limit for EDI claims. It is the responsibility of a provider's office staff or billing service to process their EDI reports as well as remittance advice summaries on a regular basis and resubmit rejected/problematic claims within the filing limit. Due to the availability of these reporting and tracking tools, it is unusual for the FCHP Claims department to expect late claim submission. Please resubmit any claims in question immediately. If the claim can not be resubmitted, office staff should reprocess the claims on paper and send them directly to Fallon Community Health Plan within your contractual time frame.

Mail or fax your filing limit appeal request to:

Fallon Community Health Plan  
Attn: Request for Claim Review/Provider Appeals  
P. O. Box 15121  
Worcester, MA 01615-0121  
Fax: 508-368-9890

### Provider Appeal Determinations

Following receipt of a completed request for claim review, FCHP will research the request and notify the provider of the determination. When the original claim denial is upheld, a letter will be sent explaining the review determination. When a review is approved, the Remittance Advice Summary or 835 file will indicate the message of Approved per Provider Appeals. All claim review determinations will be final and binding and in keeping with the provisions of your contract with FCHP.

[Request for Claim Review Form](#)

Reference  
section

**Reference A — Coding**

When you fill out a claim form, you will need to use the Health Care Financing Administration's Common Procedure Coding System (HCPCS) to tell us the nature of the procedure for which you are requesting payment. Accurate code selection is vital for accurate claims processing and payment. HCPCS consists of three code levels:

**Level I: CPT Codes**

CPT codes are used by the Centers for Medicare and Medicaid Services (CMS) to describe physician procedures and certain hospital outpatient services. CPT codes are updated annually by the American Medical Association (AMA). Providers are responsible for obtaining the update each year and for billing with the current CPT codes.

CPT modifiers are two-digit codes that may be added to the main procedure code. They allow physicians to indicate that the procedure being reported has been altered by specific circumstances.

Unlisted CPT codes should be used only when necessary. When there is no code that properly describes the service performed and an unlisted code is used, medical documentation must be attached to the claim.

**Level II: HCPCS National codes**

These codes supplement the CPT codes and provide a means to list non-physician procedures such as ambulance services, durable medical equipment, dental, specific supplies or the administration of drugs. These codes use a letter followed by four numbers.

**Level III: Local codes**

These are rarely used — only as need dictates. Local codes denote specific procedures or supplies for which there is no national code. Local level III codes were eliminated as of December 31, 2003.

**CPT coding requirements**

FCHP requires most outpatient services to be coded with HCPCS/CPT codes. These codes are not only used to define the service, but also to define the payment method (i.e., ASC payment group, fee schedule). The existence of a CPT or HCPCS code does not guarantee that the code is acceptable to FCHP or that the service is covered. The AMA is aware that CMS and other CPT-4 users may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, FCHP may independently establish policies and procedures governing the way these codes are used within our operations.

**Revenue codes**

Revenue codes identify broad service classifications rendered by institutional providers. They are four-digit codes used to describe an accommodation or ancillary service. The

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## REFERENCE SECTION

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COBRA act of 1986 requires hospital outpatient billing to make use of HCPCS coding. This requirement applies to all acute-care, long-term care, rehabilitation and psychiatric hospitals as well as hospital-based rural health clinics. HCPCS codes must be reported in tandem with specific revenue codes to describe the services rendered. Accurate code selection of both the revenue code and the CPT or HCPCS Level II code is vital for accurate claims processing and payment.

### **ICD-9-CM codes**

ICD-9-CM diagnosis codes are used to indicate patient's diagnosis or condition. An ICD-9-CM diagnosis code is required on all claims. You may submit up to eight ICD-9-CM diagnosis codes. Codes should be listed in priority order. You must use the complete ICD-9-CM diagnosis codes to the fourth or fifth digit. Claims submitted with incomplete ICD-9-CM diagnosis codes will be rejected with an explanation of "Reject Incomplete Diagnosis Code."

### **New, revised and deleted codes**

Each year, the American Medical Association and CMS review the CPT and HCPCS codes to determine whether codes should be added, revised or deleted. FCHP adheres to the standard coding guidelines of the American Medical Association in conjunction with Medicare guidelines. To make sure that contract documents and payment mechanisms remain current with industry standards, FCHP will add new codes for covered benefits to our claims payment system as contract language allows. Codes for new technology must first be reviewed by FCHP to determine whether the procedure is a covered benefit. Codes deleted by the AMA will be deactivated from our system effective January 1st of each year.

In past years, updated codes have had a 90-day grace period during which deleted codes for that year could still be used. Effective October 1, 2004 (ICD-9-CM Diagnosis and Procedure Codes) and January 1, 2005 (CPT/HCPCS Codes), the 90-day grace period has been eliminated. This change is due to the HIPAA transaction and code set rule requiring use of the medical codes set that is valid at the time that the service is provided.

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**REFERENCE SECTION**

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**Reference B — Modifiers**

Modifiers are two-digit codes that may be added to the main procedure code. They are used to indicate that the procedure being reported has been altered by specific circumstances described by the modifier. The use of modifiers eliminates the need for separate procedure listings that may describe the modifying circumstances. FCHP will accept up to four modifiers per claim line. Per Medicare guidelines, the modifier that affects payment must be submitted first.

Reimbursements listed in this section will be paid only if all FCHP procedures and referral requirements are followed.

The only Level 1 CPT-4 modifiers approved for hospital/facility use are 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79 and 91. They are indicated in the chart below by this symbol:



**Level 1 CPT-4 Modifiers**

Modifier	Name	When to use
-21	Prolonged evaluation and management services	When the service provided is prolonged or greater than that usually required for the highest level of evaluation and management service. If modifier -21 is used with low or moderate complexity evaluation and management services (99201, 99202, 99203, 99204), the claim will be rejected due to an invalid modifier/procedure combination.
-23	Unusual anesthesia	To indicate a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. <ul style="list-style-type: none"> <li>• FCHP may require medical notes.</li> </ul>

**REFERENCE SECTION**

Modifier	Name	When to use
-24	Unrelated evaluation and management service by the same physician during a postoperative period	To indicate that an E/M service was performed during a postoperative period for a reason unrelated to the original procedure. <ul style="list-style-type: none"> <li>• Attach supporting documentation.</li> </ul>
-25 <b>H</b>	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	To indicate that on the day a procedure identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service in addition to the other services provided or the preoperative and postoperative care associated with that procedure.
-26	Professional component	To indicate that the billed service is for the professional component for radiology, pathology or cardiology. The acceptance of modifier -26 with a procedure is based on CMS guidelines.
-27 <b>H</b>	Multiple outpatient hospital E/M encounters on the same date	Report the use of hospital resources for separate E/M services, <ul style="list-style-type: none"> <li>• provided to the same patient</li> <li>• by the same or different provider(s)</li> <li>• in more than one outpatient hospital setting</li> <li>• on the same date of service</li> </ul> Modifier -27 is not allowed with radiology or laboratory procedures.

**REFERENCE SECTION**

Modifier	Name	When to use
-32	Mandated services	To indicate services are related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement)
-47	Anesthesia by surgeon	<p>Regional or general anesthesia provided by the surgeon may be reported by adding the modifier -47 to the basic service. (This does not include local anesthesia.) Note: Modifier -47 would not be used as a modifier for the anesthesia procedures 00100-01999.</p> <ul style="list-style-type: none"> <li>• Reporting of this modifier is for informational purposes only.</li> </ul> <p>This service is not covered by FCHP.</p>
<p>-50</p> <p><b>H</b></p>	Bilateral procedure	<p>Surgical - To indicate bilateral procedures performed at the same operative session. Modifier -50 is used with surgical procedures (CPT-4 codes 10040-69990). Submit the procedure code on a single claim line with modifier -50 with "1" unit. Do not use this modifier to report surgical procedures already identified by their description as "bilateral."</p> <p>Radiology - Modifier -50 should not be used with radiology procedures that describe bilateral joint films.</p> <p>When reporting (bilateral) radiological services you should use the -RT and -LT modifiers. Radiological services should be billed on two claim lines with the -RT and -LT modifier and one unit on each line. Do not use the -RT and -LT modifier to report services already identified as bilateral by definition.</p>

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**REFERENCE SECTION**

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Modifier	Name	When to use
		<p>Reimbursement for bilateral services is determined by the Medicare Physician Fee Schedule Database (MPFSD), which is located at the end of the Level 1 CPT-4 Modifiers Reference Section D.</p>
-51	Multiple procedures	<p>When the same provider performs multiple procedures other than evaluation and management services at the same session, the primary procedure or service should be reported as listed. The additional procedure or service should be identified by adding the modifier -51 to its code. This modifier should not be appended to designated add-on codes.</p> <ol style="list-style-type: none"> <li>1. The use of modifier 51 will reduce reimbursement by 50% of the billing physician's or facility's contracted rate.</li> <li>2. For additional information on multiple procedures see:  Billing and payment guidelines for professional claims  Billing and payment guidelines for facility claims</li> </ol>

**REFERENCE SECTION**

Modifier	Name	When to use
<p style="text-align: center;">-52</p> <p style="text-align: center;"><b>H</b></p>	<p>Reduced services</p>	<p>To indicate that a service or procedure is partially reduced or eliminated at the physician's discretion. The reduced or eliminated procedure or service should be identified by adding the modifier -52 to its code.</p> <ol style="list-style-type: none"> <li>1. Reimbursement for reduced surgical services will be at 50% of the billing physician's contracted rate.</li> <li>2. This modifier is also recognized for radiology services.</li> </ol>
<p style="text-align: center;">-53</p>	<p>Discontinued procedure</p>	<p>To indicate that the physician has elected to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.</p> <ul style="list-style-type: none"> <li>• Reimbursement will be reduced by 50% of the billing physician's contracted rate.</li> </ul>
<p style="text-align: center;">-54</p>	<p>Surgical care only</p>	<p>When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier -54 to the usual procedure number.</p> <ul style="list-style-type: none"> <li>• Surgical only services will be reimbursed at 70% of the billing physician's contracted rate.</li> </ul>

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**REFERENCE SECTION**

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Modifier	Name	When to use
-55	Postoperative	<p>When one physician performs the postoperative management and management only another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier -55 to the usual procedure number.</p> <ol style="list-style-type: none"> <li>1. Attach supporting documentation.</li> <li>2. Postoperative management services will be reimbursed at 20% of the billing physician's contracted rate.</li> </ol>
-56	Preoperative	<p>When one physician performs the preoperative care and evaluation management only and another physician performs the surgical procedure, the pre-operative component may be identified by adding the modifier -56 to the usual procedure number. Do not attach modifier -56 to an E/M code.</p> <ul style="list-style-type: none"> <li>• Preoperative management services will be reimbursed at 10% of the billing physician's contracted rate.</li> </ul>
-57	Decision for surgery	<p>To indicate an evaluation and management service that resulted in the initial decision to perform surgery. CPT codes for use with the modifier -57 are 92002-92014 and 99201-99499. Use this modifier only in cases in which the decision for surgery was made during the preoperative period of a surgical procedure with a 90-day postoperative period (i.e., major surgery).</p>

**REFERENCE SECTION**

Modifier	Name	When to use
<p style="text-align: center;">-58</p> <p style="text-align: center;"><b>H</b></p>	<p>Staged or related procedure or service by the same physician during the postoperative period</p>	<p>To indicate that the performance of a procedure or service during the postoperative period was:</p> <ol style="list-style-type: none"> <li>1. prospectively planned with the original procedure (staged)</li> <li>2. more extensive than the original procedure</li> <li>3. for therapy following a diagnostic surgical procedure Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier -78.</li> </ol>
<p style="text-align: center;">-59</p> <p style="text-align: center;"><b>H</b></p>	<p>Distinct procedural service</p>	<p>To indicate that a procedure or service was distinct or independent from other services performed on the same day other than evaluation and management services. Modifier -59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. Use only if a more descriptive modifier is not available, and the use of modifier -59 best explains the circumstances.</p> <ol style="list-style-type: none"> <li>1. Attach supporting documentation.</li> <li>2. The first procedure may be reimbursed at 100% of the billing physician's contracted rate. All subsequent procedures will be reviewed and payment may be affected.</li> <li>3. This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.</li> </ol>

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**REFERENCE SECTION**


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Modifier	Name	When to use
-62	Two surgeons	<p>When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier '-62' to the procedure code and any associated add-on code(s) for that procedure for as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedures, are performed during the same surgical session, separate code(s) may also be reported without the modifier '-62' added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier '-80' or modifier '-82' added, as appropriate.</p>
-63	Procedure performed on infants less than 4 kg	<p>Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding the modifier '-63' to the procedure code. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier '-63' should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.</p> <ol style="list-style-type: none"> <li>1. Claims billed with modifier -63 will require the submission of operative notes if additional reimbursement is</li> </ol>

**REFERENCE SECTION**

Modifier	Name	When to use
		<p>requested.</p> <p>2. Notes will be reviewed by a Medical Director to determine appropriateness and amount of reimbursement, which may equal up to 25% of charges above what would be considered normal for a given procedure.</p>
-66	Surgical team	<p>When highly complex procedures requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment are carried out under the surgical team concept.</p> <p>1. Each physician will receive 62.5% of the billing physician's contracted rate.</p>
-73 	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	<p>Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier -73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.</p> <ul style="list-style-type: none"> <li>Reimbursement will be reduced by 50% of the facility's contracted rate.</li> </ul>

**REFERENCE SECTION**

Modifier	Name	When to use
<p>-74</p> <p><b>H</b></p>	<p>Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia</p>	<p>Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of the modifier -74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.</p>
<p>-76</p> <p><b>H</b></p>	<p>Repeat procedure</p>	<p>To indicate that a procedure or service was repeated subsequent to the original procedure or service by same physician. Reimbursement will be at 70% of the billing physician's contracted rate.</p> <ul style="list-style-type: none"> <li>This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.</li> </ul>

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**REFERENCE SECTION**

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Modifier	Name	When to use
-77  	Repeat procedure by another physician	To indicate that a basic procedure or service performed by another physician had to be repeated. <ul style="list-style-type: none"> <li>• This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.</li> </ul>
-78  	Return to the operating room for a related procedure during the postoperative period.	To indicate that another procedure was performed during the postoperative period of the initial procedure. <ul style="list-style-type: none"> <li>• Reimbursement will be at 70% of the billing physician's contracted rate.</li> </ul>
-79  	Unrelated procedure or service - postoperative period	To indicate that the performance of a procedure or service by the same physician during the post-operative period was unrelated to the original procedure. <ul style="list-style-type: none"> <li>• E/M services will not be reimbursed during postoperative period.</li> </ul>
-80	Assistant surgeon	To identify surgical assistant services, attach modifier to appropriate Surgical CPT-4 code. <ol style="list-style-type: none"> <li>1. Charges need to be submitted on a separate claim.</li> <li>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.</li> <li>3. The claim will be paid at 16% of the assistant surgeon's contracted rate.</li> </ol>

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**REFERENCE SECTION**

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Modifier	Name	When to use
-81	Minimum Assistant Surgeon	<p>Minimum surgical assistant services are identified by adding the modifier -81 to the usual procedure number. Use modifier -81 when the assistant-at-surgery is not present for the entire procedure.</p> <ol style="list-style-type: none"> <li>1. Charges need to be submitted on a separate claim.</li> <li>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.</li> <li>3. The claim will be paid at 16% of the assistant surgeon's contracted rate.</li> </ol>
-82	Assistant surgeon when qualified resident surgeon not available	<p>To identify the unavailability of a qualified resident surgeon, attach modifier to appropriate Surgical CPT-4 code.</p> <ol style="list-style-type: none"> <li>1. Charges need to be submitted on a separate claim.</li> <li>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.</li> <li>3. The claim will be paid at 16% of the assistant surgeon's contracted rate.</li> </ol>


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**REFERENCE SECTION**

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Modifier	Name	When to use
-91  	Repeat Clinical Diagnostic Laboratory Test	In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier –91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

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**REFERENCE SECTION**

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**Level II HCPCS modifiers**

The listing below does not represent the complete listing of HCPCS modifiers. Please refer to the Level II (HCPCS/National) modifiers.

Modifier	Name	When to use
-AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant-at-surgery	Use this modifier to indicate a physician assistant or nurse practitioner assisted at surgery. Claim will be reimbursed at 85% of the maximum allowed for an assistant surgeon for covered services.
-E1	Upper left, eyelid	Use to indicate anatomical site
-E2	Lower left, eyelid	
-E3	Upper right, eyelid	
-E4	Lower right, eyelid	
-FA	Left hand, thumb	
-F1	Left hand, second digit	
-F2	Left hand, third digit	
-F3	Left hand, fourth digit	
-F4	Left hand, fifth digit	
-F5	Right hand, thumb	
-F6	Right hand, second digit	
-F7	Right hand, third digit	
-F8	Right hand, fourth digit	

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**REFERENCE SECTION**

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Modifier	Name	When to use
-F9	Right hand, fifth digit	
-LC	Left circumflex coronary artery	Use this modifier with CPT codes 92980–92984, 92995 and 92996.
-LD	Left anterior descending coronary artery	Use this modifier with CPT codes 92980–92984, 92995 and 92996.
-LT	Left side (used to identify procedures performed on the left side of the body)	Use this modifier to identify procedures performed on the left side of the body. This code should not be used to report a bilateral surgical procedure. This modifier only applies to the CPT codes where bilateralism is not already inherent in the CPT code description. Use this modifier with CPT-4 codes that identify procedures performed on paired organs like ears, eyes, nostrils, kidneys, lungs, ovaries, etc. For interventional radiology services, add the –LT modifier to the surgical codes but not to the radiology supervision and interpretation codes.
-Q5	Service performed by a substitute physician under a reciprocal billing arrangement	Use this modifier when services are furnished by a substitute physician under a reciprocal billing arrangement. This modifier has no effect on payment.
-Q6	Service furnished by a locum tenens physician	Use this modifier when services are furnished by a locum tenens physician. This modifier has no effect on payment.

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**REFERENCE SECTION**

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Modifier	Name	When to use
-RC	Right coronary artery	Use this modifier with CPT codes 92980–92984, 92995 and 92996.
-RT	Right side (used to identify procedures performed on the right side of the body)	Use this modifier to identify procedures performed on the right side of the body. This code should not be used to report a bilateral surgical procedure. This modifier only applies to the CPT codes where bilateralism is not already inherent in the CPT code description. Use this modifier with CPT-4 codes that identify procedures performed on paired organs like ears, eyes, nostrils, kidneys, lungs, ovaries, etc. For interventional radiology services, add the –RT modifier to the surgical codes but not to the radiology supervision and interpretation codes.
-SA	Nurse practitioner rendering service in collaboration with a physician	Use this modifier when nurse practitioner is rendering service in collaboration with a physician.
-SB	Nurse Midwife	Use this modifier to report professional services provided independently and use reduced service modifiers to report when they have not provided all the services covered by a global allowance. Claim will be reimbursed at 80% of the applicable physician fee schedule amount.  Ancillary services should not be reported with the –SB modifier.

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**REFERENCE SECTION**

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Modifier	Name	When to use
-SL	State supplied vaccine	Use this modifier to indicate the vaccine is state supplied. FCHP does not reimburse for state supplied vaccines.
-TA	Left foot, great toe	Use to indicate anatomical site
-T1	Left foot, second digit	
-T2	Left foot, third digit	
-T3	Left foot, fourth digit	
-T4	Left foot, fifth digit	
-T5	Right foot, great toe	
-T6	Right foot, second digit	
-T7	Right foot, third digit	
-T8	Right foot, fourth digit	
-T9	Right foot, fifth digit	
-TC	Technical Component	Use to report only the technical component. Payment is based solely on the technical value of each individual procedure.

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**REFERENCE SECTION**

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**Anesthesia modifiers**

Anesthesia services require one of the following modifiers: See 4C – Billing and payment guidelines for professional claims for detailed information on billing for anesthesia services.

Modifier	Name
-AA	Anesthesia services performed personally by anesthesiologist
-AD	Medical supervision by a physician: more than four concurrent anesthesia procedures. Reimbursement will be additional three base units per procedure.
-QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals. Reimbursement will be at 50% of the allowable amount.
-QS	Monitored anesthesia care services. The QS modifier must be submitted with modifiers -G8 and -G9.
-QX	CRNA service: with medical direction by a physician. Reimbursement will be at 50% of the allowable amount.
-QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist. Reimbursement will be at 50% of the allowable amount.
-QZ	CRNA service: without medical direction by physician. Reimbursement per Medicare guidelines.

Note: The reporting of physical status modifiers or qualifying circumstances (99100 – 99140) do not affect reimbursement.

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**REFERENCE SECTION**

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**Ambulance origin and destination modifiers**

Single-digit modifiers for ambulance transport are used in combination in reporting services to CMS. The first digit indicates the transport's place of origin, and the second digit indicates the destination.

Modifier	Name
D	Diagnostic or therapeutic sites other than 'P' or 'H'
E	Residential, domiciliary or custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance vehicles
J	Non hospital-based dialysis facility
M	Ambulance arranged by provider
N	Skilled nursing facility
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Destination code only – intermediate stop at physician office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

Other Ambulance Modifier Codes

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**REFERENCE SECTION**

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GM	Multiple patients on one ambulance trip
QL	Patient pronounced dead after ambulance called/dispatched
QM	Ambulance service provided under arrangement by a provider of services (institutional-based providers)
QN	Ambulance service furnished directly by a provider of services (institutional-based providers)
TQ	Basic Life Support transport provided by a volunteer ambulance service

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**REFERENCE SECTION**

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**Reference C — Place of service codes**

These codes are used on line 24B of the CMS 1500 form.

Place of service code(s)	Place of service name	Place of service description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals.
05	Indian health service free-standing facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and non-surgical) and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian health service provider-based facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and non-surgical) and rehabilitation services, rendered by, or under the supervision of, physicians to American Indians and Alaska Natives who do not require hospitalization.
07	Tribal 638 free-standing facility	A facility or location, owned and operated by a federally recognized American Indians and Alaska Natives tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and non-surgical) and rehabilitation services, to tribal members who do not require hospitalization.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
08	Tribal 638 provider-based facility	A facility or location, owned and operated by a federally recognized American Indians and Alaska Natives tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and non-surgical) and rehabilitation services, to tribal members admitted as inpatients or outpatients.
09	<b>Prison-Correctional Facility</b>	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06).
11	Office	Location other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
14	Group home	Congregate residential foster care setting for children and adolescents in state custody that provide some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.
15	Mobile unit	A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room – hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled nursing facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services, but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility that primarily provides skilled nursing care and related services for the rehabilitation of injured, disabled or sick residents, or regularly provides health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility that provides room, board and other personal assistance services on a generally long-term basis and does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
41	Ambulance – land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – air or water	An air or water vehicle specifically designed, equipped and staffed for water lifesaving and transporting the sick or injured.
49	Independent clinic	A location, not part of a hospital and not described as any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically under-served area that provides health center Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric facility – partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization but who need broader programs than outpatient visits to a hospital-based or hospital-affiliated facility.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
53	Community mental health center	<p>A facility that provides the following services:</p> <ul style="list-style-type: none"> <li>• Outpatient services including specialized services for children, the elderly, individuals who are chronically ill and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility</li> <li>• 24 hour a day emergency care services</li> <li>• Day treatment, other partial hospitalization or psychosocial rehabilitation services</li> <li>• Patient admission screening for state mental health facilities</li> <li>• Consultation and education services.</li> </ul>
54	Intermediate care facility/ mentally retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care that provides a 24-hour, therapeutically planned and professionally staffed, group living and learning environment.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
57	Non-residential substance abuse treatment facility	A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media or paper claims or using the roster billing method. This generally takes place in a mass immunization setting like a public health center, pharmacy or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy and speech pathology services.
65	End-stage renal disease treatment facility	A facility other than a hospital that provides dialysis treatment, maintenance and training to patients or caregivers on an ambulatory or home-care basis.

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**REFERENCE SECTION**

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Place of service code(s)	Place of service name	Place of service description
71	State or local public health clinic	A facility maintained by state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural health clinic	A certified facility located in a rural medically under-served area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent laboratory	A laboratory certified to perform diagnostic and clinical tests independent of an institution or a physician's office.
99	Other unlisted facility	Other service facilities not identified above.

<http://cms.hhs.gov/states/poshome.asp>

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**REFERENCE SECTION**

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**Reference D – Bilateral procedures**

Reimbursement for bilateral services is determined by the Medicare Physician Fee Schedule Database.

Bilateral indicator	Definition	FCHP instructions
0	150% payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with -RT and -LT, the payment is based for the two sides, or the lower of the actual charges for both sides, or 100% of the fee schedule amount for a single code.	Do not submit these codes with modifier -50.
1	150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier -50, the payment is based on the lower of the total charges for both sides or 150% of the fee schedule for a single code.	Submit the procedure code on a single claim line with modifier -50 with "1" unit.  <b>See Table A below for a list of codes.</b>
2	150% payment adjustment does not apply. Relative Value Units (RVUs) are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with a modifier -50, or twice on the same day by any other means, the payment is based on both sides of the total actual charge by the physician for both sides or 100% of the fee schedule for a single code.	Do not submit these codes with modifier -50. Submit the procedure code on a single claim line with "1" unit.  <b>See Table B below for a list of codes.</b>
3	The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day, payment is based on each side or organ or site of a paired organ on the lower of the actual charge for each side, or 100% of the fee schedule amount for each side. Services in this category are generally radiology or other diagnostic tests that are not subject to the	Submit radiology procedure code on two claim lines with the -RT and -LT modifiers with "1" unit on each claim line.  <b>See Table C below for a list of codes.</b>

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**REFERENCE SECTION**

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	special payment rules for other bilateral surgeries.	
9	Bilateral concept does not apply.	Do not submit these codes with modifier -50.

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**REFERENCE SECTION**

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**Table A** – 150% payment adjustment for bilateral procedures **applies**.

**Table B** – 150% payment adjustment **does not apply**. RVU's are already based on the procedure being performed as a bilateral procedure.

**Table C** - The usual payment adjustment for bilateral procedures **does not apply**. Pay 100% of the fee schedule amount for each side or unit.

*Table A – 150% payment adjustment for bilateral procedures applies*

Code	Modifier	Description
0016T		Thermotx choroid vasc lesion
0017T		Photocoagulat macular drusen
15820		Revision of lower eyelid
15821		Revision of lower eyelid
15822		Revision of upper eyelid
15823		Revision of upper eyelid
15824		Removal of forehead wrinkles
15825		Removal of neck wrinkles
15826		Removal of brow wrinkles
15828		Removal of face wrinkles
15829		Removal of skin wrinkles
19020		Incision of breast lesion
19030		Injection for breast x-ray
19100		Bx breast percut w/o image
19101		Biopsy of breast, open
19102		Bx breast percut w/image
19103		Bx breast percut w/device
19105		Cryosurg ablate fa, each

Code	Modifier	Description
29861		Hip arthroscopy/surgery
29862		Hip arthroscopy/surgery
29863		Hip arthroscopy/surgery
29866		Autgrft implnt, knee w/scope
29867		Allgrft implnt, knee w/scope
29868		Meniscal trnspl, knee w/scpe
29870		Knee arthroscopy, dx
29871		Knee arthroscopy/drainage
29873		Knee arthroscopy/surgery
29874		Knee arthroscopy/surgery
29875		Knee arthroscopy/surgery
29876		Knee arthroscopy/surgery
29877		Knee arthroscopy/surgery
29879		Knee arthroscopy/surgery
29880		Knee arthroscopy/surgery
29881		Knee arthroscopy/surgery
29882		Knee arthroscopy/surgery
29883		Knee arthroscopy/surgery

**REFERENCE SECTION**

19110	Nipple exploration
19112	Excise breast duct fistula
19120	Removal of breast lesion
19125	Excision, breast lesion
19290	Place needle wire, breast
19296	Place po breast cath for rad
19298	Place breast rad tube/caths
19300	Removal of breast tissue
19301	Partical mastectomy
19302	P-mastectomy w/ln removal
19303	Mast, simple, complete
19304	Mast, subq
19305	Mast, radical
19306	Mast, rad, urban type
19307	Mast, mod rad
19316	Suspension of breast
19318	Reduction of large breast
19324	Enlarge breast
19325	Enlarge breast with implant
19328	Removal of breast implant
19330	Removal of implant material
19340	Immediate breast prosthesis
19342	Delayed breast prosthesis
19350	Breast reconstruction
19355	Correct inverted nipple(s)
19357	Breast reconstruction

29884	Knee arthroscopy/surgery
29885	Knee arthroscopy/surgery
29886	Knee arthroscopy/surgery
29887	Knee arthroscopy/surgery
29888	Knee arthroscopy/surgery
29889	Knee arthroscopy/surgery
29891	Ankle arthroscopy/surgery
29892	Ankle arthroscopy/surgery
29893	Scope, plantar fasciotomy
29894	Ankle arthroscopy/surgery
29895	Ankle arthroscopy/surgery
29897	Ankle arthroscopy/surgery
29898	Ankle arthroscopy/surgery
29899	Ankle arthroscopy/surgery
29900	Mcp joint arthroscopy, dx
29901	Mcp joint arthroscopy, surg
29902	Mcp joint arthroscopy, surg
29999	Arthroscopy of joint
30110	Removal of nose polyp(s)
30115	Removal of nose polyp(s)
30130	Excise inferior turbinate
30140	Resect inferior turbinate
30901	Control of nosebleed
30903	Control of nosebleed
30930	Ther fx, nasal inf turbinate
31000	Irrigation, maxillary sinus

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**REFERENCE SECTION**

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19361	Breast reconstr w/lat flap
19364	Breast reconstruction
19366	Breast reconstruction
19367	Breast reconstruction
19368	Breast reconstruction
19369	Breast reconstruction
19370	Surgery of breast capsule
19371	Removal of breast capsule
19380	Revise breast reconstruction
19396	Design custom breast implant
19499	Breast surgery procedure
20100	Explore wound, neck
20150	Excise epiphyseal bar
20526	Ther injection, carp tunnel
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20802	Replantation, arm, complete
20805	Replant forearm, complete
20808	Replantation hand, complete
20824	Replantation thumb, complete
20827	Replantation thumb, complete
20838	Replantation foot, complete
20982	Ablate, bone tumor(s) perq
21010	Incision of jaw joint
21050	Removal of jaw joint

31002	Irrigation, sphenoid sinus
31020	Exploration, maxillary sinus
31030	Exploration, maxillary sinus
31032	Explore sinus, remove polyps
31050	Exploration, sphenoid sinus
31051	Sphenoid sinus surgery
31070	Exploration of frontal sinus
31075	Exploration of frontal sinus
31080	Removal of frontal sinus
31081	Removal of frontal sinus
31084	Removal of frontal sinus
31085	Removal of frontal sinus
31086	Removal of frontal sinus
31087	Removal of frontal sinus
31090	Exploration of sinuses
31200	Removal of ethmoid sinus
31201	Removal of ethmoid sinus
31205	Removal of ethmoid sinus
31225	Removal of upper jaw
31230	Removal of upper jaw
31233	Nasal/sinus endoscopy, dx
31235	Nasal/sinus endoscopy, dx
31237	Nasal/sinus endoscopy, surg
31238	Nasal/sinus endoscopy, surg
31239	Nasal/sinus endoscopy, surg
31240	Nasal/sinus endoscopy, surg

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**REFERENCE SECTION**

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21060		Remove jaw joint cartilage
21070		Remove coronoid process
21077		Prepare face/oral prosthesis
21086		Prepare face/oral prosthesis
21240		Reconstruction of jaw joint
21242		Reconstruction of jaw joint
21243		Reconstruction of jaw joint
21280		Revision of eyelid
21282		Revision of eyelid
21480		Reset dislocated jaw
21485		Reset dislocated jaw
21490		Repair dislocated jaw
21615		Removal of rib
21616		Removal of rib and nerves
23020		Release shoulder joint
23031		Drain shoulder bursa
23035		Drain shoulder bone lesion
23040		Exploratory shoulder surgery
23044		Exploratory shoulder surgery
23065		Biopsy shoulder tissues
23066		Biopsy shoulder tissues
23075		Removal of shoulder lesion
23076		Removal of shoulder lesion
23077		Remove tumor of shoulder
23100		Biopsy of shoulder joint
23101		Shoulder joint surgery
23105		Remove shoulder joint lining

31254		Revision of ethmoid sinus
31255		Removal of ethmoid sinus
31256		Exploration maxillary sinus
31267		Endoscopy, maxillary sinus
31276		Sinus endoscopy, surgical
31287		Nasal/sinus endoscopy, surg
31288		Nasal/sinus endoscopy, surg
31290		Nasal/sinus endoscopy, surg
31291		Nasal/sinus endoscopy, surg
31292		Nasal/sinus endoscopy, surg
31293		Nasal/sinus endoscopy, surg
31294		Nasal/sinus endoscopy, surg
31545		Remove vc lesion w/scope
31546		Remove vc lesion scope/graft
31715		Injection for bronchus x-ray
32000		Drainage of chest
32002		Treatment of collapsed lung
32020		Insertion of chest tube
32491		Lung volume reduction
32664		Thoracoscopy, surgical
33889		Artery transpose/endovas taa
33891		Car-car bp grft/endovas taa
34001		Removal of artery clot
34051		Removal of artery clot
34101		Removal of artery clot
34111		Removal of arm artery clot
34151		Removal of artery clot

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**REFERENCE SECTION**

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23106		Incision of collarbone joint
23107		Explore treat shoulder joint
23125		Removal of collar bone
23130		Remove shoulder bone, part
23140		Removal of bone lesion
23145		Removal of bone lesion
23146		Removal of bone lesion
23150		Removal of humerus lesion
23155		Removal of humerus lesion
23156		Removal of humerus lesion
23170		Remove collar bone lesion
23172		Remove shoulder blade lesion
23174		Remove humerus lesion
23180		Remove collar bone lesion
23182		Remove shoulder blade lesion
23184		Remove humerus lesion
23190		Partial removal of scapula
23195		Removal of head of humerus
23200		Removal of collar bone
23210		Removal of shoulder blade
23220		Partial removal of humerus
23221		Partial removal of humerus
23222		Partial removal of humerus
23330		Remove shoulder foreign body
23331		Remove shoulder foreign body
23332		Remove shoulder foreign body
23350		Injection for shoulder x-ray

34201		Removal of artery clot
34203		Removal of leg artery clot
34401		Removal of vein clot
34421		Removal of vein clot
34451		Removal of vein clot
34471		Removal of vein clot
34490		Removal of vein clot
34501		Repair valve, femoral vein
34510		Transposition of vein valve
34520		Cross-over vein graft
34530		Leg vein fusion
34812		Xpose for endoprosth, femorl
34820		Xpose for endoprosth, iliac
34833		Xpose for endoprosth, iliac
34834		Xpose, endoprosth, brachial
34900		Endovasc iliac repr w/graft
35001		Repair defect of artery
35002		Repair artery rupture, neck
35005		Repair defect of artery
35011		Repair defect of artery
35013		Repair artery rupture, arm
35021		Repair defect of artery
35022		Repair artery rupture, chest
35045		Repair defect of arm artery
35091		Repair defect of artery
35092		Repair artery rupture, aorta
35102		Repair defect of artery

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**REFERENCE SECTION**

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23400	Fixation of shoulder blade
23410	Repair rotator cuff, acute
23412	Repair rotator cuff, chronic
23415	Release of shoulder ligament
23420	Repair of shoulder
23430	Repair biceps tendon
23440	Remove/transplant tendon
23450	Repair shoulder capsule
23455	Repair shoulder capsule
23460	Repair shoulder capsule
23462	Repair shoulder capsule
23465	Repair shoulder capsule
23466	Repair shoulder capsule
23470	Reconstruct shoulder joint
23472	Reconstruct shoulder joint
23480	Revision of collar bone
23485	Revision of collar bone
23490	Reinforce clavicle
23491	Reinforce shoulder bones
23500	Treat clavicle fracture
23505	Treat clavicle fracture
23515	Treat clavicle fracture
23520	Treat clavicle dislocation
23525	Treat clavicle dislocation
23530	Treat clavicle dislocation
23532	Treat clavicle dislocation
23540	Treat clavicle dislocation

35103	Repair artery rupture, groin
35111	Repair defect of artery
35112	Repair artery rupture, spleen
35121	Repair defect of artery
35122	Repair artery rupture, belly
35131	Repair defect of artery
35132	Repair artery rupture, groin
35141	Repair defect of artery
35142	Repair artery rupture, thigh
35151	Repair defect of artery
35152	Repair artery rupture, knee
35201	Repair blood vessel lesion
35206	Repair blood vessel lesion
35207	Repair blood vessel lesion
35211	Repair blood vessel lesion
35216	Repair blood vessel lesion
35221	Repair blood vessel lesion
35226	Repair blood vessel lesion
35231	Repair blood vessel lesion
35236	Repair blood vessel lesion
35241	Repair blood vessel lesion
35246	Repair blood vessel lesion
35251	Repair blood vessel lesion
35256	Repair blood vessel lesion
35261	Repair blood vessel lesion
35266	Repair blood vessel lesion
35271	Repair blood vessel lesion

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**REFERENCE SECTION**

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23545		Treat clavicle dislocation
23550		Treat clavicle dislocation
23552		Treat clavicle dislocation
23570		Treat shoulder blade fx
23575		Treat shoulder blade fx
23585		Treat scapula fracture
23600		Treat humerus fracture
23605		Treat humerus fracture
23615		Treat humerus fracture
23616		Treat humerus fracture
23620		Treat humerus fracture
23625		Treat humerus fracture
23630		Treat humerus fracture
23650		Treat shoulder dislocation
23655		Treat shoulder dislocation
23660		Treat shoulder dislocation
23665		Treat dislocation/fracture
23670		Treat dislocation/fracture
23675		Treat dislocation/fracture
23680		Treat dislocation/fracture
23800		Fusion of shoulder joint
23930		Drainage of arm lesion
23931		Drainage of arm bursa
23935		Drain arm/elbow bone lesion
24000		Exploratory elbow surgery
24006		Release elbow joint
24065		Biopsy arm/elbow soft tissue

35276		Repair blood vessel lesion
35281		Repair blood vessel lesion
35286		Repair blood vessel lesion
35301		Rechanneling of artery
35302		Rechanneling of artery
35303		Rechanneling of artery
35304		Rechanneling of artery
35305		Rechanneling of artery
35311		Rechanneling of artery
35321		Rechanneling of artery
35331		Rechanneling of artery
35341		Rechanneling of artery
35351		Rechanneling of artery
35355		Rechanneling of artery
35361		Rechanneling of artery
35363		Rechanneling of artery
35371		Rechanneling of artery
35372		Rechanneling of artery
35450		Repair arterial blockage
35452		Repair arterial blockage
35454		Repair arterial blockage
35456		Repair arterial blockage
35458		Repair arterial blockage
35459		Repair arterial blockage
35460		Repair venous blockage
35470		Repair arterial blockage

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**REFERENCE SECTION**

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24066		Biopsy arm/elbow soft tissue
24075		Remove arm/elbow lesion
24076		Remove arm/elbow lesion
24077		Remove tumor of arm/elbow
24100		Biopsy elbow joint lining
24101		Explore/treat elbow joint
24102		Remove elbow joint lining
24105		Removal of elbow bursa
24110		Remove humerus lesion
24115		Remove/graft bone lesion
24116		Remove/graft bone lesion
24120		Remove elbow lesion
24125		Remove/graft bone lesion
24126		Remove/graft bone lesion
24130		Removal of head of radius
24134		Removal of arm bone lesion
24136		Remove radius bone lesion
24138		Remove elbow bone lesion
24140		Partial removal of arm bone
24145		Partial removal of radius
24147		Partial removal of elbow
24149		Radical resection of elbow
24150		Extensive humerus surgery
24151		Extensive humerus surgery
24152		Extensive radius surgery
24153		Extensive radius surgery
24155		Removal of elbow joint

35471		Repair arterial blockage
35472		Repair arterial blockage
35473		Repair arterial blockage
35474		Repair arterial blockage
35475		Repair arterial blockage
35476		Repair venous blockage
35501		Artery bypass graft
35506		Artery bypass graft
35508		Artery bypass graft
35509		Artery bypass graft
35510		Artery bypass graft
35511		Artery bypass graft
35512		Artery bypass graft
35515		Artery bypass graft
35516		Artery bypass graft
35518		Artery bypass graft
35521		Artery bypass graft
35522		Artery bypass graft
35525		Artery bypass graft
35526		Artery bypass graft
35531		Artery bypass graft
35533		Artery bypass graft
35536		Artery bypass graft
35539		Artery bypass graft
35540		Artery bypass graft
35551		Artery bypass graft
35556		Artery bypass graft

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**REFERENCE SECTION**

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24160		Remove elbow joint implant
24164		Remove radius head implant
24200		Removal of arm foreign body
24201		Removal of arm foreign body
24220		Injection for elbow x-ray
24300		Manipulate elbow w/anesth
24330		Revision of arm muscles
24331		Revision of arm muscles
24332		Tenolysis, triceps
24340		Repair of biceps tendon
24341		Repair arm tendon/muscle
24342		Repair of ruptured tendon
24343		Repr elbow lat ligmnt w/tiss
24344		Reconstruct elbow lat ligmnt
24345		Repr elbw med ligmnt w/tissu
24346		Reconstruct elbow med ligmnt
24350		Repair of tennis elbow
24351		Repair of tennis elbow
24352		Repair of tennis elbow
24354		Repair of tennis elbow
24356		Revision of tennis elbow
24360		Reconstruct elbow joint
24361		Reconstruct elbow joint
24362		Reconstruct elbow joint
24363		Replace elbow joint
24365		Reconstruct head of radius
24366		Reconstruct head of radius

35558		Artery bypass graft
35560		Artery bypass graft
35563		Artery bypass graft
35565		Artery bypass graft
35566		Artery bypass graft
35571		Artery bypass graft
35583		Vein bypass graft
35585		Vein bypass graft
35587		Vein bypass graft
35601		Artery bypass graft
35606		Artery bypass graft
35612		Artery bypass graft
35616		Artery bypass graft
35621		Artery bypass graft
35623		Bypass graft, not vein
35626		Artery bypass graft
35631		Artery bypass graft
35636		Artery bypass graft
35642		Artery bypass graft
35645		Artery bypass graft
35647		Artery bypass graft
35650		Artery bypass graft
35651		Artery bypass graft
35656		Artery bypass graft
35661		Artery bypass graft
35663		Artery bypass graft
35665		Artery bypass graft

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**REFERENCE SECTION**

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24400	Revision of humerus
24410	Revision of humerus
24420	Revision of humerus
24430	Repair of humerus
24435	Repair humerus with graft
24470	Revision of elbow joint
24495	Decompression of forearm
24498	Reinforce humerus
24500	Treat humerus fracture
24505	Treat humerus fracture
24515	Treat humerus fracture
24516	Treat humerus fracture
24530	Treat humerus fracture
24535	Treat humerus fracture
24538	Treat humerus fracture
24545	Treat humerus fracture
24546	Treat humerus fracture
24560	Treat humerus fracture
24565	Treat humerus fracture
24566	Treat humerus fracture
24575	Treat humerus fracture
24576	Treat humerus fracture
24577	Treat humerus fracture
24579	Treat humerus fracture
24582	Treat humerus fracture
24586	Treat elbow fracture
24587	Treat elbow fracture

35666	Artery bypass graft
35671	Artery bypass graft
35691	Arterial transposition
35693	Arterial transposition
35694	Arterial transposition
35695	Arterial transposition
35701	Exploration, carotid artery
35721	Exploration, femoral artery
35741	Exploration popliteal artery
35761	Exploration of artery/vein
35879	Revise graft w/vein
35881	Revise graft w/vein
35883	Revise graft w/nonauto graft
35884	Revise graft w/vein
36000	Place needle in vein
36002	Pseudoaneurysm injection trt
36005	Injection ext venography
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36014	Place catheter in artery
36015	Place catheter in artery
36100	Establish access to artery
36200	Place catheter in aorta
36245	Place catheter in artery
36246	Place catheter in artery
36247	Place catheter in artery

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**REFERENCE SECTION**

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24600	Treat elbow dislocation
24605	Treat elbow dislocation
24615	Treat elbow dislocation
24620	Treat elbow fracture
24635	Treat elbow fracture
24640	Treat elbow dislocation
24650	Treat radius fracture
24655	Treat radius fracture
24665	Treat radius fracture
24666	Treat radius fracture
24670	Treat ulnar fracture
24675	Treat ulnar fracture
24685	Treat ulnar fracture
24800	Fusion of elbow joint
24802	Fusion/graft of elbow joint
24900	Amputation of upper arm
24920	Amputation of upper arm
24925	Amputation follow-up surgery
24930	Amputation follow-up surgery
24931	Amputate upper arm & implant
24935	Revision of amputation
24940	Revision of upper arm
24999	Upper arm/elbow surgery
25000	Incision of tendon sheath
25001	Incise flexor carpi radialis
25020	Decompress forearm 1 space
25023	Decompress forearm 1 space

36470	Injection therapy of vein
36471	Injection therapy of veins
36475	Endovenous rf, 1st vein
36476	Endovenous rf, vein add-on
36478	Endovenous laser, 1st vein
36479	Endovenous laser vein addon
36557	Insert tunneled cv cath
36558	Insert tunneled cv cath
36560	Insert tunneled cv cath
36561	Insert tunneled cv cath
36565	Insert tunneled cv cath
36566	Insert tunneled cv cath
36570	Insert picvad cath
36571	Insert picvad cath
36589	Removal tunneled cv cath
36598	Inj w/fluor, eval cv device
36820	Av fusion/forearm vein
36838	Dist revas ligation, hemo
36870	Percut thrombect av fistula
37184	Prim art mech thrombectomy
37187	Venous mech thrombectomy
37188	Venous m-thrombectomy add-on
37207	Transcath iv stent, open
37500	Endoscopy ligate perf veins
37501	Vascular endoscopy procedure
37609	Temporal artery procedure
37650	Revision of major vein

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**REFERENCE SECTION**

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25024		Decompress forearm 2 spaces
25025		Decompress forearm 2 spaces
25028		Drainage of forearm lesion
25031		Drainage of forearm bursa
25035		Treat forearm bone lesion
25040		Explore/treat wrist joint
25065		Biopsy forearm soft tissues
25066		Biopsy forearm soft tissues
25075		Removal forearm lesion subcu
25076		Removal forearm lesion deep
25077		Remove tumor, forearm/wrist
25085		Incision of wrist capsule
25100		Biopsy of wrist joint
25101		Explore/treat wrist joint
25105		Remove wrist joint lining
25107		Remove wrist joint cartilage
25109		Excise tendon forearm/wrist
25110		Remove wrist tendon lesion
25111		Remove wrist tendon lesion
25112		Reremove wrist tendon lesion
25115		Remove wrist/forearm lesion
25116		Remove wrist/forearm lesion
25118		Excise wrist tendon sheath
25119		Partial removal of ulna
25120		Removal of forearm lesion
25125		Remove/graft forearm lesion
25126		Remove/graft forearm lesion

37700		Revise leg vein
37718		Ligate/strip short leg vein
37722		Ligate/strip long leg vein
37735		Removal of leg veins/lesion
37765		Phleb veins - extrem - to 20
37766		Phleb veins - extrem 20+
37780		Revision of leg vein
37785		Ligate/divide/excise vein
38220		Bone marrow aspiration
38221		Bone marrow biopsy
38500		Biopsy/removal, lymph nodes
38505		Needle biopsy, lymph nodes
38510		Biopsy/removal, lymph nodes
38520		Biopsy/removal, lymph nodes
38525		Biopsy/removal, lymph nodes
38530		Biopsy/removal, lymph nodes
38542		Explore deep node(s), neck
38589		Laparoscope proc, lymphatic
38700		Removal of lymph nodes, neck
38720		Removal of lymph nodes, neck
38724		Removal of lymph nodes, neck
38740		Remove armpit lymph nodes
38745		Remove armpit lymph nodes
38760		Remove groin lymph nodes
38765		Remove groin lymph nodes
38770		Remove pelvis lymph nodes
38790		Inject for lymphatic x-ray

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**REFERENCE SECTION**

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25130	Removal of wrist lesion
25135	Remove & graft wrist lesion
25136	Remove & graft wrist lesion
25145	Remove forearm bone lesion
25150	Partial removal of ulna
25151	Partial removal of radius
25170	Extensive forearm surgery
25230	Partial removal of radius
25240	Partial removal of ulna
25246	Injection for wrist x-ray
25248	Remove forearm foreign body
25250	Removal of wrist prosthesis
25259	Manipulate wrist w/anesthes
25275	Repair forearm tendon sheath
25300	Fusion of tendons at wrist
25301	Fusion of tendons at wrist
25315	Revise palsy hand tendon(s)
25316	Revise palsy hand tendon(s)
25320	Repair/revise wrist joint
25332	Revise wrist joint
25335	Realignment of hand
25337	Reconstruct ulna/radioulnar
25350	Revision of radius
25355	Revision of radius
25360	Revision of ulna
25365	Revise radius & ulna
25370	Revise radius or ulna

38792	Identify sentinel node
40720	Repair cleft lip/nasal
43289	Laparoscope proc, esoph
43659	Laparoscope proc, stom
44238	Laparoscope proc, intestine
44979	Laparoscope proc, app
46505	Chemodenervation anal musc
47511	Insert bile duct drain
47525	Change bile duct catheter
47579	Laparoscope proc, biliary
49329	Laparo proc, abdm/per/oment
49491	Rpr hern preemie reduc
49492	Rpr ing hern premie, blocked
49495	Rpr ing hernia baby, reduc
49496	Rpr ing hernia baby, blocked
49500	Rpr ing hernia, init, reduce
49501	Rpr ing hernia, init blocked
49505	Prp i/hern init reduc >5 yr
49507	Prp i/hern init block >5 yr
49520	Rerepair ing hernia, reduce
49521	Rerepair ing hernia, blocked
49525	Repair ing hernia, sliding
49540	Repair lumbar hernia
49550	Rpr rem hernia, init, reduce
49553	Rpr fem hernia, init blocked
49555	Rerepair fem hernia, reduce
49557	Rerepair fem hernia, blocked

**REFERENCE SECTION**

25375	Revise radius & ulna
25390	Shorten radius or ulna
25391	Lengthen radius or ulna
25392	Shorten radius & ulna
25393	Lengthen radius & ulna
25394	Repair carpal bone, shorten
25400	Repair radius or ulna
25405	Repair/graft radius or ulna
25415	Repair radius & ulna
25420	Repair/graft radius & ulna
25425	Repair/graft radius or ulna
25426	Repair/graft radius & ulna
25430	Vasc graft into carpal bone
25431	Repair nonunion carpal bone
25440	Repair/graft wrist bone
25441	Reconstruct wrist joint
25442	Reconstruct wrist joint
25443	Reconstruct wrist joint
25444	Reconstruct wrist joint
25445	Reconstruct wrist joint
25446	Wrist replacement
25447	Repair wrist joint(s)
25449	Remove wrist joint implant
25450	Revision of wrist joint
25455	Revision of wrist joint
25490	Reinforce radius
25491	Reinforce ulna

49560	Rpr ventral hern init, reduc
49561	Rpr ventral hern init, block
49565	Rerepair ventrl hern, reduce
49566	Rerepair ventrl hern, block
49570	Rpr epigastric hern, reduce
49572	Rpr epigastric hern, blocked
49590	Repair spigelian hernia
49650	Laparo hernia repair initial
49651	Laparo hernia repair recur
49659	Laparo proc, hernia repair
50080	Removal of kidney stone
50081	Removal of kidney stone
50120	Exploration of kidney
50125	Explore and drain kidney
50130	Removal of kidney stone
50135	Exploration of kidney
50200	Biopsy of kidney
50205	Biopsy of kidney
50220	Remove kidney, open
50225	Removal kidney open, complex
50230	Removal kidney open, radical
50320	Remove kidney, living donor
50340	Removal of kidney
50365	Transplantation of kidney
50382	Change ureter stent, percut
50384	Remove ureter stent, percut
50387	Change ext/int ureter stent

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**REFERENCE SECTION**

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25492		Reinforce radius and ulna
25500		Treat fracture of radius
25505		Treat fracture of radius
25515		Treat fracture of radius
25520		Treat fracture of radius
25525		Treat fracture of radius
25526		Treat fracture of radius
25530		Treat fracture of ulna
25535		Treat fracture of ulna
25545		Treat fracture of ulna
25560		Treat fracture radius & ulna
25565		Treat fracture radius & ulna
25574		Treat fracture radius & ulna
25575		Treat fracture radius/ulna
25600		Treat fracture radius/ulna
25605		Treat fracture radius/ulna
25606		Treat fx distal radial
25607		Treat fx rad extra-articul
25608		Treat fx rad intra-articul
25609		Treat fx radial 3+ frag
25622		Treat wrist bone fracture
25624		Treat wrist bone fracture
25628		Treat wrist bone fracture
25630		Treat wrist bone fracture
25635		Treat wrist bone fracture
25645		Treat wrist bone fracture
25650		Treat wrist bone fracture

50389		Remove renal tube w/fluoro
50390		Drainage of kidney lesion
50392		Insert kidney drain
50393		Insert ureteral tube
50394		Injection for kidney x-ray
50395		Create passage to kidney
50396		Measure kidney pressure
50398		Change kidney tube
50545		Laparo radical nephrectomy
50547		Laparo removal donor kidney
50549		Laparoscope proc, renal
50551		Kidney endoscopy
50553		Kidney endoscopy
50555		Kidney endoscopy & biopsy
50557		Kidney endoscopy & treatment
50561		Kidney endoscopy & treatment
50570		Kidney endoscopy
50572		Kidney endoscopy
50574		Kidney endoscopy & biopsy
50575		Kidney endoscopy
50576		Kidney endoscopy & treatment
50580		Kidney endoscopy & treatment
50590		Fragmenting of kidney stone
50592		Perc rf ablate renal tumor
50600		Exploration of ureter
50605		Insert ureteral support
50610		Removal of ureter stone

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**REFERENCE SECTION**

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25651		Pin ulnar styloid fracture
25652		Treat fracture ulnar styloid
25660		Treat wrist dislocation
25670		Treat wrist dislocation
25671		Pin radioulnar dislocation
25675		Treat wrist dislocation
25676		Treat wrist dislocation
25680		Treat wrist fracture
25685		Treat wrist fracture
25690		Treat wrist dislocation
25695		Treat wrist dislocation
25800		Fusion of wrist joint
25805		Fusion/graft of wrist joint
25810		Fusion/graft of wrist joint
25820		Fusion of hand bones
25825		Fuse hand bones with graft
25830		Fusion, radioulnar jnt/ulna
25900		Amputation of forearm
25905		Amputation of forearm
25907		Amputation follow-up surgery
25909		Amputation follow-up surgery
25915		Amputation of forearm
25920		Amputate hand at wrist
25922		Amputate hand at wrist
25924		Amputation follow-up surgery
25927		Amputation of hand
25929		Amputation follow-up surgery

50620		Removal of ureter stone
50630		Removal of ureter stone
50684		Injection for ureter x-ray
50715		Release of ureter
50780		Reimplant ureter in bladder
50782		Reimplant ureter in bladder
50783		Reimplant ureter in bladder
50785		Reimplant ureter in bladder
50800		Implant ureter in bowel
50815		Urine shunt to intestine
50820		Construct bowel bladder
50840		Replace ureter by bowel
50860		Transplant ureter to skin
50940		Release of ureter
50945		Laparoscopy ureterolithotomy
50947		Laparo new ureter/bladder
50948		Laparo new ureter/bladder
50949		Laparoscope proc, ureter
50951		Endoscopy of ureter
50953		Endoscopy of ureter
50955		Ureter endoscopy & biopsy
50957		Ureter endoscopy & treatment
50961		Ureter endoscopy & treatment
50970		Ureter endoscopy
50972		Ureter endoscopy & catheter
50974		Ureter endoscopy & biopsy
50976		Ureter endoscopy & treatment

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**REFERENCE SECTION**

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25931		Amputation follow-up surgery
25999		Forearm or wrist surgery
26040		Release palm contracture
26045		Release palm contracture
26070		Explore/treat hand joint
26075		Explore/treat finger joint
26100		Biopsy hand joint lining
26105		Biopsy finger joint lining
26121		Release palm contracture
26123		Release palm contracture
26130		Remove wrist joint lining
26185		Remove finger bone
26340		Manipulate finger w/anesth
26546		Repair nonunion hand
27000		Incision of hip tendon
27001		Incision of hip tendon
27003		Incision of hip tendon
27005		Incision of hip tendon
27006		Incision of hip tendons
27025		Incision of hip/thigh fascia
27030		Drainage of hip joint
27033		Exploration of hip joint
27035		Denervation of hip joint
27036		Excision of hip joint/muscle
27040		Biopsy of soft tissues
27041		Biopsy of soft tissues
27047		Remove hip/pelvis lesion

50980		Ureter endoscopy & treatment
51535		Repair of ureter lesion
52007		Cystoscopy and biopsy
52320		Cystoscopy and treatment
52325		Cystoscopy, stone removal
52327		Cystoscopy, inject material
52330		Cystoscopy and treatment
52332		Cystoscopy and treatment
52334		Create passage to kidney
52341		Cysto w/ureter stricture tx
52342		Cysto w/up stricture tx
52343		Cysto w/renal stricture tx
52344		Cysto/uretero, stricture tx
52352		Cystouretero w/stone remove
52353		Cystouretero w/lithotripsy
52354		Cystouretero w/biopsy
52355		Cystouretero w/excise tumor
54500		Biopsy of testis
54505		Biopsy of testis
54512		Excise lesion testis
54520		Removal of testis
54522		Orchiectomy, partial
54530		Removal of testis
54535		Extensive testis surgery
54550		Exploration for testis
54560		Exploration for testis
54600		Reduce testis torsion

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**REFERENCE SECTION**

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27048		Remove hip/pelvis lesion
27049		Remove hip/pelvis lesion
27050		Remove hip/pelvis lesion
27052		Remove hip/pelvis lesion
27054		Remove hip/pelvis lesion
27060		Remove hip/pelvis lesion
27062		Remove hip/pelvis lesion
27065		Remove hip/pelvis lesion
27066		Remove hip/pelvis lesion
27067		Remove hip/pelvis lesion
27070		Remove hip/pelvis lesion
27071		Remove hip/pelvis lesion
27086		Remove hip/pelvis lesion
27087		Remove hip/pelvis lesion
27090		Remove hip/pelvis lesion
27091		Remove hip/pelvis lesion
27093		Remove hip/pelvis lesion
27095		Remove hip/pelvis lesion
27096		Remove hip/pelvis lesion
27097		Remove hip/pelvis lesion
27098		Remove hip/pelvis lesion
27100		Remove hip/pelvis lesion
27105		Remove hip/pelvis lesion
27110		Remove hip/pelvis lesion
27111		Remove hip/pelvis lesion
27120		Remove hip/pelvis lesion
27122		Remove hip/pelvis lesion

54620		Suspension of testis
54640		Suspension of testis
54650		Orchiopexy (Fowler-Stephens)
54660		Revision of testis
54670		Repair testis injury
54680		Relocation of testis(es)
54690		Laparoscopy, orchiectomy
54692		Laparoscopy, orchiopexy
54699		Laparoscope proc, testis
55060		Repair of hydrocele
55400		Repair of sperm duct
55530		Revise spermatic cord veins
55535		Revise spermatic cord veins
55540		Revise hernia & sperm veins
55550		Laparo ligate spermatic vein
55559		Laparo proc, spermatic cord
55600		Incise sperm duct pouch
55605		Incise sperm duct pouch
55650		Remove sperm duct pouch
56640		Extensive vulva surgery
58345		Reopen fallopian tube
58353		Endometr ablate, thermal
58356		Endometrial cryoablation
58578		Laparo proc, uterus
58579		Hysteroscope procedure
58672		Laparoscopy, fimbrioplasty

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**REFERENCE SECTION**

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27125		Remove hip/pelvis lesion
27130		Remove hip/pelvis lesion
27132		Remove hip/pelvis lesion
27134		Remove hip/pelvis lesion
27137		Remove hip/pelvis lesion
27138		Remove hip/pelvis lesion
27140		Remove hip/pelvis lesion
27146		Remove hip/pelvis lesion
27147		Remove hip/pelvis lesion
27151		Remove hip/pelvis lesion
27156		Remove hip/pelvis lesion
27161		Remove hip/pelvis lesion
27165		Remove hip/pelvis lesion
27170		Remove hip/pelvis lesion
27175		Remove hip/pelvis lesion
27176		Remove hip/pelvis lesion
27177		Remove hip/pelvis lesion
27178		Remove hip/pelvis lesion
27179		Remove hip/pelvis lesion
27181		Remove hip/pelvis lesion
27185		Remove hip/pelvis lesion
27187		Remove hip/pelvis lesion
27193		Remove hip/pelvis lesion
27220		Remove hip/pelvis lesion
27222		Remove hip/pelvis lesion
27226		Remove hip/pelvis lesion
27227		Remove hip/pelvis lesion

58673		Laparoscopy, salpingostomy
58679		Laparo proc, oviduct-ovary
58760		Remove tubal obstruction
58770		Create new tubal opening
59898		Laparo proc, ob care/deliver
60260		Repeat thyroid surgery
60540		Explore adrenal gland
60650		Laparoscopy adrenalectomy
60659		Laparo proc, endocrine
61154		Pierce skull & remove clot
61250		Pierce skull & explore
61330		Decompress eye socket
61340		Subtemporal decompression
61490		Incise skull for surgery
61580		Craniofacial approach, skull
61581		Craniofacial approach, skull
61584		Orbitocranial approach/skull
61585		Orbitocranial approach/skull
61590		Infratemporal approach/skull
61591		Infratemporal approach/skull
61592		Orbitocranial approach/skull
61595		Transtemporal approach/skull
61596		Transcochlear approach/skull
61597		Transcondylar approach/skull
61613		Remove aneurysm, sinus
61863		Implant neuroelectrode
61867		Implant neuroelectrode

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**REFERENCE SECTION**

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27228		Remove hip/pelvis lesion
27230		Remove hip/pelvis lesion
27232		Remove hip/pelvis lesion
27235		Remove hip/pelvis lesion
27236		Remove hip/pelvis lesion
27238		Remove hip/pelvis lesion
27240		Remove hip/pelvis lesion
27244		Remove hip/pelvis lesion
27245		Remove hip/pelvis lesion
27246		Remove hip/pelvis lesion
27248		Remove hip/pelvis lesion
27250		Remove hip/pelvis lesion
27252		Remove hip/pelvis lesion
27253		Remove hip/pelvis lesion
27254		Remove hip/pelvis lesion
27256		Remove hip/pelvis lesion
27257		Remove hip/pelvis lesion
27258		Remove hip/pelvis lesion
27259		Remove hip/pelvis lesion
27265		Remove hip/pelvis lesion
27266		Remove hip/pelvis lesion
27280		Remove hip/pelvis lesion
27284		Remove hip/pelvis lesion
27286		Remove hip/pelvis lesion
27299		Remove hip/pelvis lesion
27301		Remove hip/pelvis lesion
27303		Remove hip/pelvis lesion

61880		Revise/remove neuroelectrode
61885		Insrt/redo neurostim 1 array
61888		Revise/remove neuroreceiver
63020		Neck spine disk surgery
63030		Low back disk surgery
63035		Spinal disk surgery add-on
63040		Laminotomy, single cervical
63042		Laminotomy, single lumbar
63043		Laminotomy, add'l cervical
63044		Laminotomy, add'l lumbar
63191		Incise spinal column/nerves
64412		Nblock inj, spinal accessor
64418		Nblock inj, suprascapular
64450		Nblock, other peripheral
64470		Inj paravertebral c/t
64472		Inj paravertebral c/t add-on
64475		Inj paravertebral l/s
64476		Inj paravertebral l/s add-on
64479		Inj foramen epidural c/t
64480		Inj foramen epidural add-on
64483		Inj foramen epidural l/s
64484		Inj foramen epidural add-on
64612		Destroy nerve, face muscle
64613		Destroy nerve, neck muscle
64614		Destroy nerve, extrem musc
64622		Destr paravertebrl nerve l/s
64623		Destr paravertebral n add-on

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**REFERENCE SECTION**

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27305		Remove hip/pelvis lesion
27306		Remove hip/pelvis lesion
27307		Remove hip/pelvis lesion
27310		Remove hip/pelvis lesion
27323		Remove hip/pelvis lesion
27324		Remove hip/pelvis lesion
27325		Remove hip/pelvis lesion
27326		Remove hip/pelvis lesion
27327		Remove hip/pelvis lesion
27328		Remove hip/pelvis lesion
27329		Remove hip/pelvis lesion
27330		Remove hip/pelvis lesion
27331		Remove hip/pelvis lesion
27332		Remove hip/pelvis lesion
27333		Remove hip/pelvis lesion
27334		Remove hip/pelvis lesion
27335		Remove hip/pelvis lesion
27340		Remove hip/pelvis lesion
27345		Remove hip/pelvis lesion
27347		Remove hip/pelvis lesion
27350		Remove hip/pelvis lesion
27355		Remove hip/pelvis lesion
27356		Remove hip/pelvis lesion
27357		Remove hip/pelvis lesion
27360		Remove hip/pelvis lesion
27365		Remove hip/pelvis lesion
27370		Remove hip/pelvis lesion

64626		Destr paravertebrl nerve c/t
64627		Destr paravertebral n add-on
64640		Injection treatment of nerve
64721		Carpal tunnel surgery
64744		Incise nerve, back of head
64761		Incision of pelvis nerve
64763		Incise hip/thigh nerve
64766		Incise hip/thigh nerve
64802		Remove sympathetic nerves
64804		Remove sympathetic nerves
64809		Remove sympathetic nerves
64818		Remove sympathetic nerves
64821		Remove sympathetic nerves
64822		Remove sympathetic nerves
64823		Remove sympathetic nerves
65091		Revise eye
65093		Revise eye with implant
65101		Removal of eye
65103		Remove eye/insert implant
65105		Remove eye/attach implant
65110		Removal of eye
65112		Remove eye/revise socket
65114		Remove eye/revise socket
65125		Revise ocular implant
65130		Insert ocular implant
65135		Insert ocular implant
65140		Attach ocular implant

**REFERENCE SECTION**

27372	Remove hip/pelvis lesion
27380	Remove hip/pelvis lesion
27381	Remove hip/pelvis lesion
27385	Remove hip/pelvis lesion
27386	Remove hip/pelvis lesion
27400	Remove hip/pelvis lesion
27403	Remove hip/pelvis lesion
27405	Remove hip/pelvis lesion
27407	Remove hip/pelvis lesion
27409	Remove hip/pelvis lesion
27412	Remove hip/pelvis lesion
27415	Remove hip/pelvis lesion
27418	Remove hip/pelvis lesion
27420	Remove hip/pelvis lesion
27422	Remove hip/pelvis lesion
27424	Remove hip/pelvis lesion
27425	Remove hip/pelvis lesion
27427	Remove hip/pelvis lesion
27428	Remove hip/pelvis lesion
27429	Remove hip/pelvis lesion
27430	Remove hip/pelvis lesion
27435	Remove hip/pelvis lesion
27437	Remove hip/pelvis lesion
27438	Remove hip/pelvis lesion
27440	Remove hip/pelvis lesion
27441	Remove hip/pelvis lesion
27442	Remove hip/pelvis lesion

65150	Revise ocular implant
65155	Reinsert ocular implant
65175	Removal of ocular implant
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65235	Remove foreign body from eye
65260	Remove foreign body from eye
65265	Remove foreign body from eye
65270	Repair of eye wound
65272	Repair of eye wound
65273	Repair of eye wound
65275	Repair of eye wound
65280	Repair of eye wound
65285	Repair of eye wound
65286	Repair of eye wound
65290	Repair of eye socket wound
65400	Removal of eye lesion
65410	Biopsy of cornea
65420	Removal of eye lesion
65426	Removal of eye lesion
65430	Corneal smear
65435	Curette/treat cornea
65436	Curette/treat cornea
65450	Treatment of corneal lesion
65600	Revision of cornea

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**REFERENCE SECTION**

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27443		Remove hip/pelvis lesion
27445		Remove hip/pelvis lesion
27446		Remove hip/pelvis lesion
27447		Remove hip/pelvis lesion
27448		Remove hip/pelvis lesion
27450		Remove hip/pelvis lesion
27454		Remove hip/pelvis lesion
27455		Remove hip/pelvis lesion
27457		Remove hip/pelvis lesion
27465		Remove hip/pelvis lesion
27466		Remove hip/pelvis lesion
27468		Remove hip/pelvis lesion
27470		Remove hip/pelvis lesion
27472		Remove hip/pelvis lesion
27475		Surgery to stop leg growth
27477		Surgery to stop leg growth
27479		Surgery to stop leg growth
27485		Surgery to stop leg growth
27486		Revise/replace knee joint
27487		Revise/replace knee joint
27488		Removal of knee prosthesis
27495		Reinforce thigh
27496		Decompression of thigh/knee
27497		Decompression of thigh/knee
27498		Decompression of thigh/knee
27499		Decompression of thigh/knee

65710		Corneal transplant
65730		Corneal transplant
65750		Corneal transplant
65755		Corneal transplant
65770		Revise cornea with implant
65772		Correction of astigmatism
65775		Correction of astigmatism
65780		Ocular reconst, transplant
65781		Ocular reconst, transplant
65782		Ocular reconst, transplant
65800		Drainage of eye
65805		Drainage of eye
65810		Drainage of eye
65815		Drainage of eye
65820		Relieve inner eye pressure
65850		Incision of eye
65855		Laser surgery of eye
65860		Incise inner eye adhesions
65865		Incise inner eye adhesions
65870		Incise inner eye adhesions
65875		Incise inner eye adhesions
65880		Incise inner eye adhesions
65900		Remove eye lesion
65920		Remove implant of eye
65930		Remove blood clot from eye
66020		Injection treatment of eye
66030		Injection treatment of eye

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**REFERENCE SECTION**

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27500	Treatment of thigh fracture
27501	Treatment of thigh fracture
27502	Treatment of thigh fracture
27503	Treatment of thigh fracture
27506	Treatment of thigh fracture
27507	Treatment of thigh fracture
27508	Treatment of thigh fracture
27509	Treatment of thigh fracture
27510	Treatment of thigh fracture
27511	Treatment of thigh fracture
27513	Treatment of thigh fracture
27514	Treatment of thigh fracture
27516	Treat thigh fx growth plate
27517	Treat thigh fx growth plate
27519	Treat thigh fx growth plate
27520	Treat kneecap fracture
27524	Treat kneecap fracture
27530	Treat knee fracture
27532	Treat knee fracture
27535	Treat knee fracture
27536	Treat knee fracture
27538	Treat knee fracture(s)
27540	Treat knee fracture
27550	Treat knee dislocation
27552	Treat knee dislocation
27556	Treat knee dislocation
27557	Treat knee dislocation

66130	Remove eye lesion
66150	Glaucoma surgery
66155	Glaucoma surgery
66160	Glaucoma surgery
66165	Glaucoma surgery
66170	Glaucoma surgery
66172	Incision of eye
66180	Implant eye shunt
66185	Revise eye shunt
66220	Repair eye lesion
66225	Repair/graft eye lesion
66250	Follow-up surgery of eye
66500	Incision of iris
66505	Incision of iris
66600	Remove iris and lesion
66605	Removal of iris
66625	Removal of iris
66630	Removal of iris
66635	Removal of iris
66680	Repair iris & ciliary body
66682	Repair iris & ciliary body
66700	Destruction, ciliary body
66710	Ciliary transsleral therapy
66711	Ciliary endoscopic ablation
66720	Destruction, ciliary body
66740	Destruction, ciliary body
66761	Revision of iris

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**REFERENCE SECTION**

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27558	Treat knee dislocation
27560	Treat kneecap dislocation
27562	Treat kneecap dislocation
27566	Treat kneecap dislocation
27580	Fusion of knee
27590	Amputate leg at thigh
27591	Amputate leg at thigh
27592	Amputate leg at thigh
27594	Amputation follow-up surgery
27596	Amputation follow-up surgery
27598	Amputate lower leg at knee
27599	Leg surgery procedure
27600	Decompression of lower leg
27601	Decompression of lower leg
27602	Decompression of lower leg
27603	Drain lower leg lesion
27604	Drain lower leg bursa
27605	Incision of achilles tendon
27606	Incision of achilles tendon
27607	Treat lower leg bone lesion
27610	Explore/treat ankle joint
27612	Exploration of ankle joint
27613	Biopsy lower leg soft tissue
27614	Biopsy lower leg soft tissue
27615	Remove tumor, lower leg
27618	Remove lower leg lesion
27619	Remove lower leg lesion

66762	Revision of iris
66770	Removal of inner eye lesion
66820	Incision, secondary cataract
66821	After cataract laser surgery
66825	Reposition intraocular lens
66830	Removal of lens lesion
66840	Removal of lens material
66850	Removal of lens material
66852	Removal of lens material
66920	Extraction of lens
66930	Extraction of lens
66940	Extraction of lens
66982	Cataract surgery, complex
66983	Cataract surg w/iol, 1 stage
66984	Cataract surg w/iol, 1 stage
66985	Insert lens prosthesis
66986	Exchange lens prosthesis
66999	Eye surgery procedure
67005	Partial removal of eye fluid
67010	Partial removal of eye fluid
67015	Release of eye fluid
67025	Replace eye fluid
67027	Implant eye drug system
67028	Injection eye drug
67030	Incise inner eye strands
67031	Laser surgery, eye strands
67036	Removal of inner eye fluid

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**REFERENCE SECTION**

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27620		Explore/treat ankle joint
27625		Remove ankle joint lining
27626		Remove ankle joint lining
27630		Removal of tendon lesion
27635		Remove lower leg bone lesion
27637		Remove/graft leg bone lesion
27638		Remove/graft leg bone lesion
27640		Partial removal of tibia
27641		Partial removal of fibula
27645		Extensive lower leg surgery
27646		Extensive lower leg surgery
27647		Extensive ankle/heel surgery
27648		Injection for ankle x-ray
27650		Repair achilles tendon
27652		Repair/graft achilles tendon
27654		Repair of achilles tendon
27656		Repair leg fascia defect
27675		Repair lower leg tendons
27676		Repair lower leg tendons
27687		Revision of calf tendon
27690		Revise lower leg tendon
27691		Revise lower leg tendon
27695		Repair of ankle ligament
27696		Repair of ankle ligaments
27698		Repair of ankle ligament
27700		Revision of ankle joint
27702		Reconstruct ankle joint

67038		Strip retinal membrane
67039		Laser treatment of retina
67040		Laser treatment of retina
67101		Repair detached retina
67105		Repair detached retina
67107		Repair detached retina
67108		Repair detached retina
67110		Repair detached retina
67112		Rerepair detached retina
67115		Release encircling material
67120		Remove eye implant material
67121		Remove eye implant material
67141		Treatment of retina
67145		Treatment of retina
67208		Treatment of retinal lesion
67210		Treatment of retinal lesion
67218		Treatment of retinal lesion
67220		Treatment of choroid lesion
67227		Treatment of retinal lesion
67228		Treatment of retinal lesion
67250		Reinforce eye wall
67255		Reinforce/graft eye wall
67299		Eye surgery procedure
67311		Revise eye muscle
67312		Revise two eye muscles
67314		Revise eye muscle
67316		Revise two eye muscles

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**REFERENCE SECTION**

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27703	Reconstruction, ankle joint
27704	Removal of ankle implant
27705	Incision of tibia
27707	Incision of fibula
27709	Incision of tibia & fibula
27712	Realignment of lower leg
27715	Revision of lower leg
27720	Repair of tibia
27722	Repair/graft of tibia
27724	Repair/graft of tibia
27725	Repair of lower leg
27727	Repair of lower leg
27730	Repair of tibia epiphysis
27732	Repair of fibula epiphysis
27734	Repair lower leg epiphyses
27740	Repair of leg epiphyses
27742	Repair of leg epiphyses
27745	Reinforce tibia
27750	Treatment of tibia fracture
27752	Treatment of tibia fracture
27756	Treatment of tibia fracture
27758	Treatment of tibia fracture
27759	Treatment of tibia fracture
27760	Treatment of ankle fracture
27762	Treatment of ankle fracture
27766	Treatment of ankle fracture
27780	Treatment of fibula fracture

67318	Revise eye muscle(s)
67343	Release eye tissue
67345	Destroy nerve of eye muscle
67346	Biopsy, eye muscle
67399	Eye muscle surgery procedure
67400	Explore/biopsy eye socket
67405	Explore/drain eye socket
67412	Explore/treat eye socket
67413	Explore/treat eye socket
67414	Explr/decompress eye socket
67415	Aspiration, orbital contents
67420	Explore/treat eye socket
67430	Explore/treat eye socket
67440	Explore/drain eye socket
67445	Explr/decompress eye socket
67450	Explore/biopsy eye socket
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67550	Insert eye socket implant
67560	Revise eye socket implant
67570	Decompress optic nerve
67599	Orbit surgery procedure
67700	Drainage of eyelid abscess
67710	Incision of eyelid
67715	Incision of eyelid fold
67810	Biopsy of eyelid

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**REFERENCE SECTION**

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27781	Treatment of fibula fracture
27784	Treatment of fibula fracture
27786	Treatment of ankle fracture
27788	Treatment of ankle fracture
27792	Treatment of ankle fracture
27808	Treatment of ankle fracture
27810	Treatment of ankle fracture
27814	Treatment of ankle fracture
27816	Treatment of ankle fracture
27818	Treatment of ankle fracture
27822	Treatment of ankle fracture
27823	Treatment of ankle fracture
27824	Treat lower leg fracture
27825	Treat lower leg fracture
27826	Treat lower leg fracture
27827	Treat lower leg fracture
27828	Treat lower leg fracture
27829	Treat lower leg joint
27830	Treat lower leg dislocation
27831	Treat lower leg dislocation
27832	Treat lower leg dislocation
27840	Treat ankle dislocation
27842	Treat ankle dislocation
27846	Treat ankle dislocation
27848	Treat ankle dislocation
27870	Fusion of ankle joint, open
27871	Fusion of tibiofibular joint

67820	Revise eyelashes
67825	Revise eyelashes
67830	Revise eyelashes
67835	Revise eyelashes
67840	Remove eyelid lesion
67850	Treat eyelid lesion
67875	Closure of eyelid by suture
67880	Revision of eyelid
67882	Revision of eyelid
67900	Repair brow defect
67901	Repair eyelid defect
67902	Repair eyelid defect
67903	Repair eyelid defect
67904	Repair eyelid defect
67906	Repair eyelid defect
67908	Repair eyelid defect
67909	Revise eyelid defect
67911	Revise eyelid defect
67912	Correction eyelid w/implant
67914	Repair eyelid defect
67915	Repair eyelid defect
67916	Repair eyelid defect
67917	Repair eyelid defect
67921	Repair eyelid defect
67922	Repair eyelid defect
67923	Repair eyelid defect
67924	Repair eyelid defect

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**REFERENCE SECTION**

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27880	Amputation of lower leg
27881	Amputation of lower leg
27882	Amputation of lower leg
27884	Amputation follow-up surgery
27886	Amputation follow-up surgery
27888	Amputation of foot at ankle
27889	Amputation of foot at ankle
27892	Decompression of leg
27893	Decompression of leg
27894	Decompression of leg
27899	Leg/ankle surgery procedure
28008	Incision of foot fascia
28043	Excision of foot lesion
28045	Excision of foot lesion
28046	Resection of tumor, foot
28050	Biopsy of foot joint lining
28052	Biopsy of foot joint lining
28054	Biopsy of toe joint lining
28060	Partial removal, foot fascia
28086	Excise foot tendon sheath
28088	Excise foot tendon sheath
28090	Removal of foot lesion
28100	Removal of ankle/heel lesion
28102	Remove/graft foot lesion
28103	Remove/graft foot lesion
28110	Part removal of metatarsal
28111	Part removal of metatarsal

67930	Repair eyelid wound
67935	Repair eyelid wound
67938	Remove eyelid foreign body
67950	Revision of eyelid
67961	Revision of eyelid
67966	Revision of eyelid
67971	Reconstruction of eyelid
67973	Reconstruction of eyelid
67974	Reconstruction of eyelid
67975	Reconstruction of eyelid
67999	Revision of eyelid
68020	Incise/drain eyelid lining
68040	Treatment of eyelid lesions
68100	Biopsy of eyelid lining
68110	Remove eyelid lining lesion
68115	Remove eyelid lining lesion
68130	Remove eyelid lining lesion
68135	Remove eyelid lining lesion
68200	Treat eyelid by injection
68320	Revise/graft eyelid lining
68325	Revise/graft eyelid lining
68326	Revise/graft eyelid lining
68328	Revise/graft eyelid lining
68330	Revise eyelid lining
68335	Revise/graft eyelid lining
68340	Separate eyelid adhesions
68360	Revise eyelid lining

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**REFERENCE SECTION**

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28112	Part removal of metatarsal
28113	Part removal of metatarsal
28114	Removal of metatarsal heads
28116	Revision of foot
28118	Removal of heel bone
28119	Removal of heel spur
28120	Part removal of ankle/heel
28122	Partial removal of foot bone
28124	Partial removal of toe
28130	Removal of ankle bone
28190	Removal of foot foreign body
28192	Removal of foot foreign body
28193	Removal of foot foreign body
28238	Revision of foot tendon
28240	Release of big toe
28250	Revision of foot fascia
28260	Release of midfoot joint
28261	Revision of foot tendon
28262	Revision of foot and ankle
28264	Release of midfoot joint
28270	Release of foot contracture
28272	Release of toe joint, each
28280	Fusion of toes
28285	Repair of hammertoe
28289	Repair hallux rigidus
28290	Correction of bunion
28292	Correction of bunion

68362	Revise eyelid lining
68371	Harvest eye tissue, alograft
68399	Eyelid lining surgery
68400	Incise/drain tear gland
68420	Incise/drain tear sac
68440	Incise tear duct opening
68500	Removal of tear gland
68505	Partial removal, tear gland
68510	Biopsy of tear gland
68520	Removal of tear sac
68525	Biopsy of tear sac
68530	Clearance of tear duct
68540	Remove tear gland lesion
68550	Remove tear gland lesion
68700	Repair tear ducts
68705	Revise tear duct opening
68720	Create tear sac drain
68745	Create tear duct drain
68750	Create tear duct drain
68760	Close tear duct opening
68761	Close tear duct opening
68770	Close tear system fistula
68801	Dilate tear duct opening
68810	Probe nasolacrimal duct
68811	Probe nasolacrimal duct
68815	Probe nasolacrimal duct
68840	Explore/irrigate tear ducts

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**REFERENCE SECTION**

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28293		Correction of bunion
28294		Correction of bunion
28296		Correction of bunion
28297		Correction of bunion
28298		Correction of bunion
28299		Correction of bunion
28300		Incision of heel bone
28302		Incision of ankle bone
28304		Incision of midfoot bones
28305		Incise/graft midfoot bones
28306		Incision of metatarsal
28307		Incision of metatarsal
28308		Incision of metatarsal
28309		Incision of metatarsals
28315		Removal of sesamoid bone
28400		Treatment of heel fracture
28405		Treatment of heel fracture
28406		Treatment of heel fracture
28415		Treat heel fracture
28420		Treat/graft heel fracture
28430		Treatment of ankle fracture
28435		Treatment of ankle fracture
28436		Treatment of ankle fracture
28445		Treat ankle fracture
28750		Fusion of big toe joint
28755		Fusion of big toe joint
28760		Fusion of big toe joint

68850		Injection for tear sac x-ray
68899		Tear duct system surgery
69220		Clean out mastoid cavity
69222		Clean out mastoid cavity
69300		Revise external ear
69420		Incision of eardrum
69421		Incision of eardrum
69424		Remove ventilating tube
69433		Create eardrum opening
69436		Create eardrum opening
69440		Exploration of middle ear
69450		Eardrum revision
69501		Mastoidectomy
69502		Mastoidectomy
69505		Remove mastoid structures
69511		Extensive mastoid surgery
69530		Extensive mastoid surgery
69535		Remove part of temporal bone
69540		Remove ear lesion
69550		Remove ear lesion
69552		Remove ear lesion
69554		Remove ear lesion
69601		Mastoid surgery revision
69602		Mastoid surgery revision
69603		Mastoid surgery revision
69604		Mastoid surgery revision
69605		Mastoid surgery revision

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**REFERENCE SECTION**

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28800		Amputation of midfoot
28805		Amputation thru metatarsal
28890		High energy eswt, plantar f
29065		Application of long arm cast
29075		Application of forearm cast
29085		Apply hand/wrist cast
29086		Apply finger cast
29105		Apply long arm splint
29125		Apply forearm splint
29126		Apply forearm splint
29130		Application of finger splint
29131		Application of finger splint
29260		Strapping of elbow or wrist
29280		Strapping of hand or finger
29345		Application of long leg cast
29355		Application of long leg cast
29358		Apply long leg cast brace
29365		Application of long leg cast
29405		Apply short leg cast
29425		Apply short leg cast
29435		Apply short leg cast
29440		Addition of walker to cast
29445		Apply rigid leg cast
29450		Application of leg cast
29505		Application, long leg splint
29515		Application lower leg splint
29580		Application of paste boot

69610		Repair of eardrum
69620		Repair of eardrum
69631		Repair eardrum structures
69632		Rebuild eardrum structures
69633		Rebuild eardrum structures
69635		Repair eardrum structures
69636		Rebuild eardrum structures
69637		Rebuild eardrum structures
69641		Revise middle ear & mastoid
69642		Revise middle ear & mastoid
69643		Revise middle ear & mastoid
69644		Revise middle ear & mastoid
69645		Revise middle ear & mastoid
69646		Revise middle ear & mastoid
69650		Release middle ear bone
69660		Revise middle ear bone
69661		Revise middle ear bone
69662		Revise middle ear bone
69666		Repair middle ear structures
69667		Repair middle ear structures
69670		Remove mastoid air cells
69676		Remove middle ear nerve
69700		Close mastoid fistula
69711		Remove/repair hearing aid
69714		Implant temple bone w/stimul
69715		Temple bne implnt w/stimulat
69717		Temple bone implant revision

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**REFERENCE SECTION**

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29705		Removal/revision of cast
29710		Removal/revision of cast
29750		Wedging of clubfoot cast
29800		Jaw arthroscopy/surgery
29804		Jaw arthroscopy/surgery
29805		Shoulder arthroscopy, dx
29806		Shoulder arthroscopy/surgery
29807		Shoulder arthroscopy/surgery
29819		Shoulder arthroscopy/surgery
29820		Shoulder arthroscopy/surgery
29821		Shoulder arthroscopy/surgery
29822		Shoulder arthroscopy/surgery
29823		Shoulder arthroscopy/surgery
29824		Shoulder arthroscopy/surgery
29825		Shoulder arthroscopy/surgery
29826		Shoulder arthroscopy/surgery
29827		Arthroscop rotator cuff repr
29830		Elbow arthroscopy
29834		Elbow arthroscopy/surgery
29835		Elbow arthroscopy/surgery
29836		Elbow arthroscopy/surgery
29837		Elbow arthroscopy/surgery
29838		Elbow arthroscopy/surgery
29840		Wrist arthroscopy
29843		Wrist arthroscopy/surgery
29844		Wrist arthroscopy/surgery
29845		Wrist arthroscopy/surgery

69718		Revise temple bone implant
69720		Release facial nerve
69725		Release facial nerve
69740		Repair facial nerve
69745		Repair facial nerve
69799		Middle ear surgery procedure
69801		Incise inner ear
69802		Incise inner ear
69805		Explore inner ear
69806		Explore inner ear
69820		Establish inner ear window
69840		Revise inner ear window
69905		Remove inner ear
69910		Remove inner ear & mastoid
69915		Incise inner ear nerve
69930		Implant cochlear device
69949		Inner ear surgery procedure
69950		Incise inner ear nerve
69955		Release facial nerve
69960		Release inner ear canal
69970		Remove inner ear lesion
69979		Temporal bone surgery
95866		Muscle test, hemidiaphragm
95866	26	Muscle test, hemidiaphragm
95866	TC	Muscle test, hemidiaphragm
95934		H-reflex test
95934	26	H-reflex test

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**REFERENCE SECTION**

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29846		Wrist arthroscopy/surgery
29847		Wrist arthroscopy/surgery
29848		Wrist endoscopy/surgery
29850		Knee arthroscopy/surgery
29851		Knee arthroscopy/surgery
29855		Tibial arthroscopy/surgery
29856		Tibial arthroscopy/surgery
29860		Hip arthroscopy, dx

95934	TC	H-reflex test
95936		H-reflex test
95936	26	H-reflex test
95936	TC	H-reflex test
G0186		Dstry eye lesn, fdr vssl tech
G0289		Arthro, loose body + chondro
G0392		AV fistula or graft arterial
G0393		AV fistula or graft venous

**REFERENCE SECTION**

*Table B – 150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.*

Code	Modifier	Description
11010		Debride skin, fx
11011		Debride skin/muscle, fx
11012		Debride skin/muscle/bone, fx
21193		Reconst lwr jaw w/o graft
21194		Reconst lwr jaw w/graft
21195		Reconst lwr jaw w/o fixation
21196		Reconst lwr jaw w/fixation
27158		Revision of pelvis
27392		Incision of thigh tendons
27395		Lengthening of thigh tendons
30801		Ablate inf turbinate, superf
30802		Cauterization, inner nose
30905		Control of nosebleed
30906		Repeat control of nosebleed
31231		Nasal endoscopy, dx
32853		Lung transplant, double
32854		Lung transplant with bypass
33880		Endovasc taa repr incl subcl
33881		Endovasc taa repr w/o subcl

Code	Modifier	Description
76645		Us exam, breast(s)
76645	26	Us exam, breast(s)
76645	TC	Us exam, breast(s)
77057		Mammogram, screening
77057	26	Mammogram, screening
77057	TC	Mammogram, screening
77059		Mri, both breasts
77059	26	Mri, both breasts
77059	TC	Mri, both breasts
78458		Ven thrombosis images, bilat
78458	26	Ven thrombosis images, bilat
78458	TC	Ven thrombosis images, bilat
92002		Eye exam, new patient
92004		Eye exam, new patient
92012		Eye exam established pat
92014		Eye exam & treatment
92020		Special eye evaluation
92060		Special eye evaluation
92060	26	Special eye evaluation

**REFERENCE SECTION**

33976		Implant ventricular device
33978		Remove ventricular device
34803		Endovas aaa repr w/3-p part
35549		Artery bypass graft
37185		Prim art m-thrombect add-on
37186		Sec art m-thrombect add-on
38562		Removal, pelvic lymph nodes
38571		Laparoscopy, lymphadenectomy
38572		Laparoscopy, lymphadenectomy
40701		Repair cleft lip/nasal
40702		Repair cleft lip/nasal
40843		Reconstruction of mouth
42507		Parotid duct diversion
42508		Parotid duct diversion
42509		Parotid duct diversion
42510		Parotid duct diversion
50540		Revision of horseshoe kidney
51575		Removal of bladder & nodes
51585		Removal of bladder & nodes
51595		Remove bladder/revise tract
51820		Revision of urinary tract
52290		Cystoscopy and treatment
52300		Cystoscopy and treatment

92060	TC	Special eye evaluation
92065		Orthoptic/pleoptic training
92065	26	Orthoptic/pleoptic training
92065	TC	Orthoptic/pleoptic training
92081		Visual field examination(s)
92081	26	Visual field examination(s)
92081	TC	Visual field examination(s)
92082		Visual field examination(s)
92082	26	Visual field examination(s)
92082	TC	Visual field examination(s)
92083		Visual field examination(s)
92083	26	Visual field examination(s)
92083	TC	Visual field examination(s)
92100		Serial tonometry exam(s)
92120		Tonography & eye evaluation
92130		Water provocation tonography
92136		Ophthalmic biometry
92136	TC	Ophthalmic biometry
92140		Glaucoma provocative tests
92250		Eye exam with photos
92250	26	Eye exam with photos
92250	TC	Eye exam with photos
92260		Ophthalmoscopy/dynamometry

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**REFERENCE SECTION**

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52301		Cystoscopy and treatment
54130		Remove penis & nodes
54135		Remove penis & nodes
54430		Revision of penis
54901		Fusion of spermatic ducts
55041		Removal of hydroceles
55200		Incision of sperm duct
55250		Removal of sperm duct(s)
55300		Prepare, sperm duct x-ray
55450		Ligation of sperm duct
55815		Extensive prostate surgery
55845		Extensive prostate surgery
55865		Extensive prostate surgery
56632		Extensive vulva surgery
57109		Vaginectomy partial w/nodes
57111		Remove vagina tissue, compl
57112		Vaginectomy w/nodes, compl
57531		Removal of cervix, radical
58210		Extensive hysterectomy
58548		Lap radical hyst
58565		Hysteroscopy, sterilization
58600		Division of fallopian tube
58605		Division of fallopian tube

92265		Eye muscle evaluation
92265	26	Eye muscle evaluation
92265	TC	Eye muscle evaluation
92270		Electro-oculography
92270	26	Electro-oculography
92270	TC	Electro-oculography
92275		Electroretinography
92275	26	Electroretinography
92275	TC	Electroretinography
92283		Color vision examination
92283	26	Color vision examination
92283	TC	Color vision examination
92284		Dark adaptation eye exam
92284	26	Dark adaptation eye exam
92284	TC	Dark adaptation eye exam
92285		Eye photography
92285	26	Eye photography
92285	TC	Eye photography
92286		Internal eye photography
92286	26	Internal eye photography
92286	TC	Internal eye photography
92287		Internal eye photography
92312		Contact lens fitting

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**REFERENCE SECTION**

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58700		Removal of fallopian tube
58720		Removal of ovary/tube(s)
58800		Drainage of ovarian cyst(s)
58805		Drainage of ovarian cyst(s)
58900		Biopsy of ovary(s)
58920		Partial removal of ovary(s)
58925		Removal of ovarian cyst(s)
58940		Removal of ovary(s)
58950		Resect ovarian malignancy
58951		Resect ovarian malignancy
58952		Resect ovarian malignancy
58953		Tah, rad dissect for debulk
58954		Tah rad debulk/lymph remove
58956		Bso, omentectomy w/tah
58957		Resect recurrent gyn mal
58958		Resect recur gyn mal w/lym
61000		Remove cranial cavity fluid
61001		Remove cranial cavity fluid
61253		Pierce skull & explore
63045		Removal of spinal lamina
63046		Removal of spinal lamina
63047		Removal of spinal lamina
63295		Repair of laminectomy defect

92316		Prescription of contact lens
92552		Pure tone audiometry, air
92553		Audiometry, air & bone
92555		Speech threshold audiometry
92556		Speech audiometry, complete
92557		Comprehensive hearing test
92561		Bekesy audiometry, diagnosis
92562		Loudness balance test
92563		Tone decay hearing test
92564		Sisi hearing test
92565		Stenger test, pure tone
92567		Tympanometry
92568		Acoustic refl threshold tst
92569		Acoustic reflex decay test
92571		Filtered speech hearing test
92572		Staggered spondaic word test
92575		Sensorineural acuity test
92576		Synthetic sentence test
92577		Stenger test, speech
92579		Visual audiometry (vra)
92582		Conditioning play audiometry
92583		Select picture audiometry
92584		Electrocochleography

**REFERENCE SECTION**

64600		Injection treatment of nerve
69210		Remove impacted ear wax
70330		X-ray exam of jaw joints
70330	26	X-ray exam of jaw joints
70330	TC	X-ray exam of jaw joints
71060		Contrast x-ray of bronchi
71060	26	Contrast x-ray of bronchi
71060	TC	Contrast x-ray of bronchi
71110		X-ray exam of ribs
71110	26	X-ray exam of ribs
71110	TC	X-ray exam of ribs
71111		X-ray exam of ribs/chest
71111	26	X-ray exam of ribs/chest
71111	TC	X-ray exam of ribs/chest
73050		X-ray exam of shoulders
73050	26	X-ray exam of shoulders
73050	TC	X-ray exam of shoulders
73520		X-ray exam of hips
73520	26	X-ray exam of hips
73520	TC	X-ray exam of hips
73565		X-ray exam of knees
73565	26	X-ray exam of knees
73565	TC	X-ray exam of knees

92585		Auditor evoke potent, compre
92585	26	Auditor evoke potent, compre
92585	TC	Auditor evoke potent, compre
92586		Auditor evoke potent, limit
92587		Evoked auditory test
92587	26	Evoked auditory test
92587	TC	Evoked auditory test
92588		Evoked auditory test
92588	26	Evoked auditory test
92588	TC	Evoked auditory test
92596		Ear protector evaluation
92620		Auditory function, 60 min
92621		Auditory function, + 15 min
92625		Tinnitus assessment
92626		Eval aud rehab status
92627		Eval aud status rehab add-on
92640		Aud brainstem implt programg
93875		Extracranial study
93875	26	Extracranial study
93875	TC	Extracranial study
93880		Extracranial study
93880	26	Extracranial study
93880	TC	Extracranial study

**REFERENCE SECTION**

75662		Artery x-rays, head & neck
75662	26	Artery x-rays, head & neck
75662	TC	Artery x-rays, head & neck
75671		Artery x-rays, head & neck
75671	26	Artery x-rays, head & neck
75671	TC	Artery x-rays, head & neck
75680		Artery x-rays, neck
75680	26	Artery x-rays, neck
75680	TC	Artery x-rays, neck
75716		Artery x-rays, arms/legs
75716	26	Artery x-rays, arms/legs
75716	TC	Artery x-rays, arms/legs
75724		Artery x-rays, kidneys
75724	26	Artery x-rays, kidneys
75724	TC	Artery x-rays, kidneys
75733		Artery x-rays, adrenals
75733	26	Artery x-rays, adrenals
75733	TC	Artery x-rays, adrenals
75743		Artery x-rays, lungs
75743	26	Artery x-rays, lungs
75743	TC	Artery x-rays, lungs
75803		Lymph vessel x-ray, arms/legs
75803	26	Lymph vessel x-ray, arms/legs

93922		Extremity study
93922	26	Extremity study
93922	TC	Extremity study
93923		Extremity study
93923	26	Extremity study
93923	TC	Extremity study
93924		Extremity study
93924	26	Extremity study
93924	TC	Extremity study
93925		Lower extremity study
93925	26	Lower extremity study
93925	TC	Lower extremity study
93930		Upper extremity study
93930	26	Upper extremity study
93930	TC	Upper extremity study
93965		Extremity study
93965	26	Extremity study
93965	TC	Extremity study
93970		Extremity study
93970	26	Extremity study
93970	TC	Extremity study
95865		Muscle test, larynx
95865	26	Muscle test, larynx

**REFERENCE SECTION**

75803	TC	Lymph vessel x-ray, arms/legs
75807		Lymph vessel x-ray, trunk
75807	26	Lymph vessel x-ray, trunk
75807	TC	Lymph vessel x-ray, trunk
75822		Vein x-ray, arms/legs
75822	26	Vein x-ray, arms/legs
75822	TC	Vein x-ray, arms/legs
75833		Vein x-ray, kidneys
75833	26	Vein x-ray, kidneys
75833	TC	Vein x-ray, kidneys
75842		Vein x-ray, adrenal glands
75842	26	Vein x-ray, adrenal glands
75842	TC	Vein x-ray, adrenal glands
76102		Complex body section x-rays
76102	26	Complex body section x-rays
76102	TC	Complex body section x-rays
76514		Echo exam of eye, thickness
76514	26	Echo exam of eye, thickness
76514	TC	Echo exam of eye, thickness
76516		Echo exam of eye
76516	26	Echo exam of eye
76516	TC	Echo exam of eye

95865	TC	Muscle test, larynx
95868		Muscle test cran nerve bilat
95868	26	Muscle test cran nerve bilat
95868	TC	Muscle test cran nerve bilat
95925		Somatosensory testing
95925	26	Somatosensory testing
95925	TC	Somatosensory testing
95926		Somatosensory testing
95926	26	Somatosensory testing
95926	TC	Somatosensory testing
95930		Visual evoked potential test
95930	26	Visual evoked potential test
95930	TC	Visual evoked potential test
96000		Motion analysis, video/3d
96001		Motion test w/ft press meas
96002		Dynamic surface emg
96003		Dynamic fine wire emg
96004		Phys review of motion tests
G0202		Screeningmammographydigital
G0202	26	Screeningmammographydigital
G0202	TC	Screeningmammographydigital
G0204		Diagnosticmammographydigital
G0204	26	Diagnosticmammographydigital

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**REFERENCE SECTION**

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76519		Echo exam of eye
76519	TC	Echo exam of eye

G0204	TC	Diagnostic mammography digital
G0268		Removal of impacted wax md

**REFERENCE SECTION**

*Table C - The usual payment adjustment for bilateral procedures does not apply. Pay 100% of the fee schedule amount for each side or unit.*

Code	Modifier	Description
70030		X-ray eye for foreign body
70030	26	X-ray eye for foreign body
70030	TC	X-ray eye for foreign body
70120		X-ray exam of mastoids
70120	26	X-ray exam of mastoids
70120	TC	X-ray exam of mastoids
70130		X-ray exam of mastoids
70130	26	X-ray exam of mastoids
70130	TC	X-ray exam of mastoids
70190		X-ray exam of eye sockets
70190	26	X-ray exam of eye sockets
70190	TC	X-ray exam of eye sockets
70332		X-ray exam of jaw joint
70332	26	X-ray exam of jaw joint
70332	TC	X-ray exam of jaw joint
70336		Magnetic image, jaw joint
70336	26	Magnetic image, jaw joint
70336	TC	Magnetic image, jaw joint
70554		Fmri brain by tech
70554	26	Fmri brain by tech
70554	TC	Fmri brain by tech
70555		Fmri brain by phys/psych
70555	26	Fmri brain by phys/psych
70555	TC	Fmri brain by phys/psych
73000		X-ray exam of collar bone

Code	Modifier	Description
73530	TC	X-ray exam of hip
73550		X-ray exam of thigh
73550	26	X-ray exam of thigh
73550	TC	X-ray exam of thigh
73560		X-ray exam of knee, 1 or 2
73560	26	X-ray exam of knee, 1 or 2
73560	TC	X-ray exam of knee, 1 or 2
73562		X-ray exam of knee, 3
73562	26	X-ray exam of knee, 3
73562	TC	X-ray exam of knee, 3
73564		X-ray exam, knee, 4 or more
73564	26	X-ray exam, knee, 4 or more
73564	TC	X-ray exam, knee, 4 or more
73580		Contrast x-ray of knee joint
73580	26	Contrast x-ray of knee joint
73580	TC	Contrast x-ray of knee joint
73590		X-ray exam of lower leg
73590	26	X-ray exam of lower leg
73590	TC	X-ray exam of lower leg
73592		X-ray exam of leg, infant
73592	26	X-ray exam of leg, infant
73592	TC	X-ray exam of leg, infant
73600		X-ray exam of ankle
73600	26	X-ray exam of ankle
73600	TC	X-ray exam of ankle

**REFERENCE SECTION**

73000	26	X-ray exam of collar bone
73000	TC	X-ray exam of collar bone
73010		X-ray exam of shoulder blade
73010	26	X-ray exam of shoulder blade
73010	TC	X-ray exam of shoulder blade
73020		X-ray exam of shoulder
73020	26	X-ray exam of shoulder
73020	TC	X-ray exam of shoulder
73030		X-ray exam of shoulder
73030	26	X-ray exam of shoulder
73030	TC	X-ray exam of shoulder
73040		Contrast x-ray of shoulder
73040	26	Contrast x-ray of shoulder
73040	TC	Contrast x-ray of shoulder
73060		X-ray exam of humerus
73060	26	X-ray exam of humerus
73060	TC	X-ray exam of humerus
73070		X-ray exam of elbow
73070	26	X-ray exam of elbow
73070	TC	X-ray exam of elbow
73080		X-ray exam of elbow
73080	26	X-ray exam of elbow
73080	TC	X-ray exam of elbow
73085		Contrast x-ray of elbow
73085	26	Contrast x-ray of elbow
73085	TC	Contrast x-ray of elbow
73090		X-ray exam of forearm
73090	26	X-ray exam of forearm
73090	TC	X-ray exam of forearm

73610		X-ray exam of ankle
73610	26	X-ray exam of ankle
73610	TC	X-ray exam of ankle
73615		Contrast x-ray of ankle
73615	26	Contrast x-ray of ankle
73615	TC	Contrast x-ray of ankle
73620		X-ray exam of foot
73620	26	X-ray exam of foot
73620	TC	X-ray exam of foot
73630		X-ray exam of foot
73630	26	X-ray exam of foot
73630	TC	X-ray exam of foot
73650		X-ray exam of heel
73650	26	X-ray exam of heel
73650	TC	X-ray exam of heel
73660		X-ray exam of toe(s)
73660	26	X-ray exam of toe(s)
73660	TC	X-ray exam of toe(s)
73700		Ct lower extremity w/o dye
73700	26	Ct lower extremity w/o dye
73700	TC	Ct lower extremity w/o dye
73701		Ct lower extremity w/dye
73701	26	Ct lower extremity w/dye
73701	TC	Ct lower extremity w/dye
73702		Ct lwr extremity w/o&w/dye
73702	26	Ct lwr extremity w/o&w/dye
73702	TC	Ct lwr extremity w/o&w/dye
73706		Ct angio lwr extr w/o&w/dye
73706	26	Ct angio lwr extr w/o&w/dye

**REFERENCE SECTION**

73092		X-ray exam of arm, infant
73092	26	X-ray exam of arm, infant
73092	TC	X-ray exam of arm, infant
73100		X-ray exam of wrist
73100	26	X-ray exam of wrist
73100	TC	X-ray exam of wrist
73110		X-ray exam of wrist
73110	26	X-ray exam of wrist
73110	TC	X-ray exam of wrist
73115		Contrast x-ray of wrist
73115	26	Contrast x-ray of wrist
73115	TC	Contrast x-ray of wrist
73120		X-ray exam of hand
73120	26	X-ray exam of hand
73120	TC	X-ray exam of hand
73130		X-ray exam of hand
73130	26	X-ray exam of hand
73130	TC	X-ray exam of hand
73140		X-ray exam of finger(s)
73140	26	X-ray exam of finger(s)
73140	TC	X-ray exam of finger(s)
73200		Ct upper extremity w/o dye
73200	26	Ct upper extremity w/o dye
73200	TC	Ct upper extremity w/o dye
73201		Ct upper extremity w/dye
73201	26	Ct upper extremity w/dye
73201	TC	Ct upper extremity w/dye
73202		Ct uppr extremity w/o & w/dye
73202	26	Ct uppr extremity w/o & w/dye

73706	TC	Ct angio lwr extr w/o&w/dye
73718		Mri lower extremity w/o dye
73718	26	Mri lower extremity w/o dye
73718	TC	Mri lower extremity w/o dye
73719		Mri lower extremity w/dye
73719	26	Mri lower extremity w/dye
73719	TC	Mri lower extremity w/dye
73720		Mri lwr extremity w/o & w/dye
73720	26	Mri lwr extremity w/o & w/dye
73720	TC	Mri lwr extremity w/o & w/dye
73721		Mri jnt of lwr extre w/o dye
73721	26	Mri jnt of lwr extre w/o dye
73721	TC	Mri jnt of lwr extre w/o dye
73722		Mri joint of lwr extr w/dye
73722	26	Mri joint of lwr extr w/dye
73722	TC	Mri joint of lwr extr w/dye
73723		Mri joint lwr extr w/o & w/dye
73723	26	Mri joint lwr extr w/o & w/dye
73723	TC	Mri joint lwr extr w/o & w/dye
73725		Mr ang lwr ext w or w/o dye
73725	26	Mr ang lwr ext w or w/o dye
73725	TC	Mr ang lwr ext w or w/o dye
75685		Artery x-rays, spine
75685	26	Artery x-rays, spine
75685	TC	Artery x-rays, spine
76510		Ophth us, b & quant a
76510	26	Ophth us, b & quant a
76510	TC	Ophth us, b & quant a
76511		Ophth us, quant a only

**REFERENCE SECTION**

73202	TC	Ct uppr extremity w/o & w/dye
73218		Mri upper extremity w/o dye
73218	26	Mri upper extremity w/o dye
73218	TC	Mri upper extremity w/o dye
73219		Mri upper extremity w/dye
73219	26	Mri upper extremity w/dye
73219	TC	Mri upper extremity w/dye
73220		Mri uppr extremity w/o & w/dye
73220	26	Mri uppr extremity w/o & w/dye
73220	TC	Mri uppr extremity w/o & w/dye
73221		Mri joint upr extrem w/o dye
73221	26	Mri joint upr extrem w/o dye
73221	TC	Mri joint upr extrem w/o dye
73222		Mri joint upr extrem w/dye
73222	26	Mri joint upr extrem w/dye
73222	TC	Mri joint upr extrem w/dye
73223		Mri joint upr extr w/o & w/dye
73223	26	Mri joint upr extr w/o & w/dye
73223	TC	Mri joint upr extr w/o & w/dye
73525		Contrast x-ray of hip
73525	26	Contrast x-ray of hip
73525	TC	Contrast x-ray of hip
73530		X-ray exam of hip
73530	26	X-ray exam of hip
92240	TC	Icg angiography

76511	26	Ophth us, quant a only
76511	TC	Ophth us, quant a only
76512		Ophth us, b w/non-quant a
76512	26	Ophth us, b w/non-quant a
76512	TC	Ophth us, b w/non-quant a
76513		Echo exam of eye, water bath
76513	26	Echo exam of eye, water bath
76513	TC	Echo exam of eye, water bath
76519	26	Echo exam of eye
76529		Echo exam of eye
76529	26	Echo exam of eye
76529	TC	Echo exam of eye
77071		X-ray stress view
92070		Fitting of contact lens
92135		Ophthalmic dx imaging
92135	26	Ophthalmic dx imaging
92135	TC	Ophthalmic dx imaging
92136	26	Ophthalmic biometry
92225		Special eye exam, initial
92226		Special eye exam, subsequent
92230		Eye exam with photos
92235		Eye exam with photos
92235	26	Eye exam with photos
92235	TC	Eye exam with photos
92240		Icg angiography
92240	26	Icg angiography